

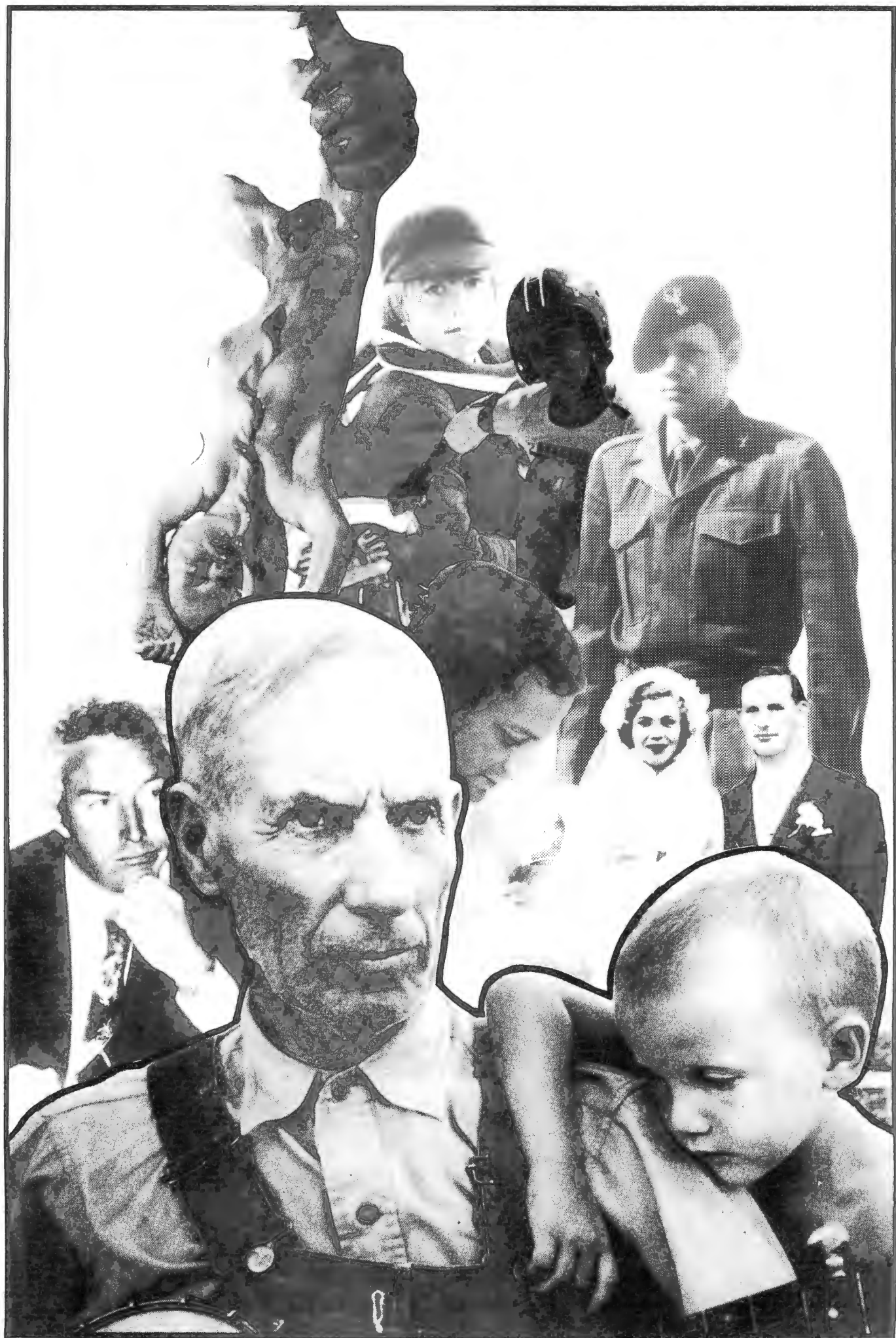
An attempt to minimize the adjustment reaction of aged home entrants in the Greater Cape Town Area.

Hugh I. Joffe, August 1979.

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To my beloved parents

‘Old age, especially an honoured old age,
has so great authority, that this is of more
value than all the pleasures of youth.’
Cicero.



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Abstract.

The literature indicates that admission to an aged home produces a severe crisis for the aged newcomer. The symptoms resulting from this final move are an increase in affective disturbance (anxiety, depression, hostility and suspiciousness), cognitive disequilibrium (confusion, disorientation and mental disorganization) and social withdrawal (apathy). The present study was designed to assess the efficacy of two different treatment approaches in attenuating this stress. 90 elderly persons admitted into 9 aged homes, a cross-section taken from the Greater Cape Town area, were randomly assigned to one of three groups : (a) Crisis Intervention Group (C.I.) subjects were seen twice weekly for five consecutive weeks in an attempt to minimise the expected adjustment reaction. (b) Social Attachment and Activity Group (S.A.) subjects were seen once a week for the same time period to support the new resident through this difficult transition. (c) Control Group subjects received no treatment either previous or subsequent to location in the home. Treatment conditions were compared using a within-subject and between-group pre-test post-test follow-up design. Biological, psychological and social levels of functioning were assessed with a battery of tests at three points : on admission to the home, in the sixth week, and finally, in the third month of residency. Results clearly indicate that the C.I. treatment was the most effective. The nature of the C.I. approach lends itself to wide use by those who have had no specialized training in psychotherapy. This has important implications for the ready improvement of present conditions in residential institutions for the aged.

CHAPTER 1

‘To know how to grow old
is the master work of wisdom,
and one of the most difficult chapters
in the great art of living’
Henri Frederic Amiel.



Introduction.

The aging process- a brief overview.

1.0 Definitions of Aging:

One of the extensive changes brought about by modern medicine has been the increase in the percentage population of elderly people and their life expectancy. Good health and longer life, however, have created new difficulties for older people and their families. Society, as a corporate body, is now being forced to confront the associated problems of longevity. Increasing numbers of biologists and social scientists are being attracted to this new field of knowledge. In so doing, they have realised that the aged are not a homogenous group. They are the young old, the old-old, black and white, rich and poor, urban

and rural, of varying backgrounds and cultures. "To add to that diversity, aging is an intensely felt experience. Its fabric is a colourful kaleidoscope of genetic inheritance, physiological and psychological deficits, socio-economic vectors, the timelessness of the unconscious, and the secret personal legend lurking in all of us as it comes to grips with reality and the universality of the human condition ... (Weinberg, 1977, p.xv).

Cowdry (1942), a biologist, did not offer a formal definition, but did make a statement that is an equivalent. "Since almost all living organisms pass through a sequence of changes, characterised by growth, development, maturation and finally senescence, aging presents a broad biological problem" (Cowdry, 1942, p.xv). He went on to enunciate the two conflicting views held by scientists at that time ...

One considers aging as an involuntary process which operates cumulatively with the passage of time, and is revealed in different organ systems as inevitable modifications of cells, tissues and fluids. The other view interprets the changes found in aged organs as structural alterations due to infections, toxins, trauma and nutritional disturbances or inadequacies giving rise to what are called degenerative changes and impairments.

(Cowdry, 1942, p.xvi).

This view was modified by Comfort (1956) who presented a narrower definition of aging. "Senescence is a change in behaviour of the organism with age, which leads to decreased power of survival and adjustment" (p.190). Handler (1960) offered a more specific definition ...

Aging is the deterioration of a mature organism resulting from time-dependent essentially irreversible changes intrinsic to all

members of a species, such that, with the passage of time, they become increasingly unable to cope with the stresses of the environment, thereby increasing the probability of death (p.200).

The biologists were soon to relinquish the monopoly of studying aging, and social scientists began to offer their definitions. Hutchinson (1955) defines old age as "that point in an individual's life when he ceases to perform all those duties, and enjoy all those rights, which were his during mature adulthood, when he began to take on a new system of rights and duties." (p.1) Developmental psychologists, on the other hand, began to consider the differences between maturation and aging. ...

Developmental psychology usually refers to the differentiation of the organism up to the age of physical maturity, and aging refers to the changes or differentiation after the age of physical maturity. While adult behaviour can have its antecedents in childhood and distinctions between development and aging may be somewhat arbitrary, if not undesirable, development does appear to be characterised by increases in size, form and function of the organism in a somewhat parallel fashion with age. In contrast, after physical maturity is reached, there may be selective reductions in function or reorganization in functions and structures. (Birren & Renner, 1977, p.3).

Thus we can begin to see that aging is a complex phenomenon that can be viewed at a number of levels from a variety of perspectives. Aging has biological, psychological, and social components and individuals age in all three spheres. Furthermore, the rates of biological, psychological, and social aging may be different in the same individual. In the light

of this realisation we cannot begin to regard the above definitions as being conclusive and explanatory, and what tends to happen in practice, is that researchers differentiate and consider these dependent variables as three separate aspects of human age and aging.

1.1 Types of Age :

We have seen from the previous section that the scientific study of human aging is a vast subject. It reaches into the biological and medical sciences, the social and behavioural sciences, and even into technology and the natural sciences. Aging has been variously defined and used by researchers from different disciplines - a fact which has complicated the interdisciplinary approach to, and understanding of this concept.

Since investigators frequently consider different dependent variables in their research on aging, it is imperative to take a close look at these.

(a) Biological age : This is an estimate of an individual's present position with respect to his potential life span. It includes an assessment of the functional capacities of the vital life-limiting organ systems, as well as prognostication of life expectancy. A person with a young biological age has a longer life expectancy than someone who is considered old.

(b) Psychological age : This looks at the individual's adaptive capacities to changing environmental demands, as he develops throughout the life cycle. Psychological age is influenced by the state of the brain and the cardiovascular system but also involves the study of memory, learning, intelligence, skills, feeling, motivation, and emotions. It assesses how an individual copes with environmental demands relative to others of his age.

(c) Social age : This refers to roles and social habits of an individual with respect to other members of society. "Compared with the expectations of his group and society, does an individual behave younger or older than one would expect from his chronological age? Since the basis of age-graded, expected behaviour is a product of one's culture, both biological and psychological characteristics of individuals enter the societal norms and the values of society" (Birren & Renner, 1977, p.5). To the sociologist and anthropologist, age is a major dimension of social organisation, and in considering the life course, protagonists of this approach place major emphasis on social timetables and assess how social age regulates the individual's behaviour and self-perception.

1.2 Towards a Multi-dimensional/Interactive Theory :

Does an integrated theory of aging exist? Cowdry (1942) was one of the first to point out that a general theory of aging was extremely difficult, if not impossible to formulate. The rationale for his belief, was based on his difficulty in accepting the assumption that the rate or expression of aging is a uniform process.

In attempting to answer the question as to the present status of theory development in gerontology some thirty years later, it is the author's opinion that despite specific advances within each discipline attempting to understand the aging process, no integrative improvements have been made. Therefore the psychology of aging is predominantly a problem and data orientated area of research. Lowenthal (1977) suggests that psychologists studying aging have developed certain concepts and hypotheses to explain or predict limited aspects of behaviour. Because there is a great diversity in the subject matter, there has been little or

no pressure to produce a unifying, all inclusive theory of how behaviour becomes organized and changes over time. What seems to happen, however, is that researchers consider only one of the four possible options available: (a) biological (b) behavioural (c) social or (d) the results of interactions between these three. Once this is done, the major task of explaining psychological aging and development tends to be incorporated in a broad metatheoretical framework. The rationale being that there is no monolithic strategy for the search for determinancy and causality, nor any single causative agent for a given outcome; causality has constructive and representational features and the evaluation of predictive or explanatory statements is guided by criteria of precision, scope and deployability (Baltes & Willis, 1977).

The current trends within gerontology favour the development of an interactive metatheoretical position. In previous decades, the split between subject and object characterised the psychologist's desire to imitate the conception and thereby the success of the natural sciences. Riegel and Wozniak (1975) argue that rather than generating knowledge on the basis of such a separation, the epistemological foundations for gerontology should lie in the dialectical interactions between the changing individual and the changing world.

The Dialectical model examines changes and interactions of events within and between individuals ...

In recognizing the co-determination of experience and action by inner-biological and cultural sociological changes, dialectical theory de-emphasizes individual psychological development in the traditional abstract sense. Instead it focuses upon concrete human beings and gradual modifications (neurological, physiological) or sudden shifts (accidents, diseases) in their biological make-up

that force them to change constructively their individual psychological operations and, thereby, also the social conditions under which they live. At the same time, a dialectical interpretation focuses upon gradual modifications (increase in available time) or sudden shifts (birth of children, promotion, loss of friends) in the cultural-sociological conditions that force the human beings to change constructively their individual psychological operations and thereby, their inner biological state. (Riegel, 1977, p.88)

Therefore individual psychological development is seen in its intimate and mutual determination by inner biological and cultural sociological shifts and changes.

It is via such a multi-dimensional analysis that one hopes to create better articulation of theory and a shift from descriptive to explanatory processes. Psychological theories do not stand serene, complete and unchallenged at some higher level of abstraction. They are part of a dynamic and pluralistic exchange between scientists and their efforts to represent a complex and continuously changing phenomenon. If my assumptions about future trends are correct, presumably we will witness more interactive research taking place. The spirit of the present study embellishes just such a standpoint.

1.3 Who is Considered Old :

Aging begins with conception and is a process of change which is continuous. The life course is usually viewed as a progression of orderly changes from infancy through to old age, with both biological and sociocultural timetables governing the sequences of change. Most current literature is at pains to point out that a multi-dimensional approach is needed when studying time related patterns; that social, biological and

psychological age should be separately measured, and that chronological age is a poor index of any of the three.

Buttler and Lewis (1977) suggest ...

The selection of age 65 for use as demarcation between middle and old age is an arbitrary one borrowed from the social legislation of Chancellor Otto von Bismarck in Germany in the 1880's. This definition of old age has been adhered to for social purposes - as a measure of determining the point of retirement or the point of eligibility for various services available to the elderly (p.4)

Chronological age is at best a rough indicator of the individual's position on any one of numerous physical or psychological dimensions because of individual differences in development. Furthermore, from a socio-cultural perspective chronological age is meaningless unless there is knowledge of the particular culture and social meaning attached to chronological ages.

American gerontologists have attempted to deal with the unreliable concept of "oldness" by dividing old age into two groups, early old age 65-74, and advanced old age, 75 and above. Despite this, it is important to realize that age is a convenient yet frequently inaccurate indicator of a person's physical and mental status and must not be relied on too heavily for evidence about human beings. (ibid)

Neugarten and Hagestad (1976) have suggested that despite its shortcomings, chronological age is an indispensable index in our society, and from an historical perspective, perhaps an increasingly important one. As institutions become more bureaucratized, and as administrative procedures become more complex, the needs for record keeping and for simple ways of categorizing people make age an increasingly convenient marker.

In this research project, age 60 has been used as a demarcation point, since the South African legislation regarding old age pensions entitles men at age 65 and women at age 60 to receive such benefits. Furthermore, most of our homes for the aged admit residents from age 60 onwards. Whatever its limitations are, we have no choice but to use chronological age in much of the discussion that follows.

1.4 Basic Processes and the Aging Individual:

(a) Physical changes and their effects : The transition from a well stabilized psychological maturity of the personality to one of decline starts at various ages, and although it may have its basis in physical change, it is really a psychological change. When one begins to look back at one's past with fond nostalgia and at the future with apprehension and feelings of insecurity, when the past becomes the good old days and the present and the future disturbing, aging has begun.

The outward manifestations of physical alterations experienced by the elderly are greying of hair, loss of hair and teeth, elongation of ears and nose, and subcutaneous fat losses. Postural changes occur in which aging is characterised by a shortening of the trunk and a tendency to long extremities. Muscular changes show a loss of elasticity and atrophy associated partly with disuse, and partly with loss of bulk and irreversible shrinking. Neuromuscular co-ordination is impaired and consequently movements are slower and not as precise as in younger people. Weight shows a tendency to increase during later middle age, and then to fall in years after that. Lymphoid tissues tend to reduce and be replaced by fat and fibrous tissue, with a redistribution of fat to abdomen and hips.

The overall physical health of the body plays a critical role in determining the energies and adaptive capacities available to the elderly.

It is common knowledge that older people experience a good deal more acute and chronic disease than the younger population. Cardiovascular and locomotor afflictions are particularly debilitating, especially when they affect the integrative systems of the body - the endocrine, vascular and central nervous systems. Perceptual losses of eyesight and hearing can deplete energy and cause social isolation.

The above-mentioned types of physical disability lead to a disquieting insecurity for the aged person, as the ego is directly challenged. The decrease of ego-efficiency in the aged almost invariably produces symptoms of anxiety when re-adjustment is necessary. To avoid anxiety, the individual resorts to old methods of coping, no matter how faulty they are. People are loath to give up automatized and habitual patterns of behaviour, and react to new situations with fear, hostility and irritability. The person's desire for homeostasis produces a tenacious clinging to a world in which he has achieved his maximal instinctual gratification and the nearest approach to a mastery of the environment. Conservation and psychic rigidity are in essence ego defences against anxiety, yet it is this rigidity that keeps the aged out of step with the ever changing world.

(b) Intellectual changes : A decline in intellectual functioning has long been considered one of the major signs of the principal mental illnesses of old age - that is, chronic brain syndrome due to senility or to arteriosclerosis. On the other hand, intellectual decline has also been considered part of the "normal" aging process. Earlier studies of intellectual abilities of elderly people came to the relatively simple conclusions that intellectual power does wear with increasing years. Recent studies have been more and more concerned, however, with whether some of the decline might not be artifactual (for example, because of differences in education among age groups) and whether certain specific

functions are impaired in old age. Currently, the concensus seems to be that speed, sensory acuity, manipulative ability, flexibility, and learning, decline the most; whereas the ability to tap stored information (vocabulary, general information, simple arithmetical computations) does not decline appreciably and, indeed, may increase until a fairly advanced age.

The many studies that do report decline in intelligence with age have, for the most part, been based on cross-sectional data. The few studies that are longitudinal and also follow subjects into ages over sixty are much less likely to report a statistically significant decline in test performance with increasing age. Berkowitz & Green (1963) note this discrepancy in results between longitudinal and cross-sectional studies, and recommend the longitudinal methods be used for studying relationships involving age. According to Eisdorfer (1965) empirical data concerning intellectual changes in the aged has itself been complex and contradictory. Because there has been a lack of uniformity in gathering data, and sampling problems have cropped up persistently, it is not surprising that very few generalizations can be made.

(c) A process of loss: Aging is a process of loss. We have already seen that the viability and adaptability of the body decrease. In addition to physical deterioration, there is a loss of responsibility and autonomy in social discourse, together with the losses, too, of old friends and cherished relationships.

In most western societies the aged face social neglect after the age of 65. Society provides few supports and little encouragement and if an individual is to adapt successfully to these changes, it is his/her responsibility to forge his/her own roles when and where possible. The dignity of the aged comes largely from their own determined effort.

Dignity is often identified with defiance, that is, with the maintenance of self-respect under pressure. Denied access to the usual powers which bring recognition in our society, old people employ defiance as a tactic to gain confirmation of their worth from an unwilling world. Perhaps "management problems" within institutions can often be seen as cries for dignity and recognition.

Persons of a given chronological age are designated old and society acts towards them in a special way as if they were old. An example of this is compulsory retirement, or specifications of an age at which one becomes eligible for pensions, regardless of ability.

To all intents and purposes our society has no functional place for the old, and we have created few acceptable roles for the elderly. The resources that are made available to help them cope with the end of their lives are inadequate and few ways are open for older people to make use of the experiences they have gathered in earlier life. The great western and narcissistic emphasis on individuality and control make the concept of decline, natural deterioration, and death an outrage, rather than the logical and necessary process of old life making way for new.

(d) A changing self-concept : Erikson (1963) believes that the major task for the later years is dealing with ego integrity versus despair. The older person must maintain the wholeness, the adequacy, the meaning of self, in the face of stresses and losses that can readily bring about despair. The self concept is the image the individual has of himself. It reflects his actual experiences and the way he interprets these experiences, his actual self and the way he interprets this self. Two of the most important components of the self concept, are self esteem and body image. Each of these is influenced by the aging process, and each, in turn, affects the psychosocial aspects of the aging process.

Given the fact that stresses, losses, and diminished physical capacities come with increasing age, one would hypothesize that peoples' self esteem should drop, perhaps drastically, as they enter their later years. This commonsense prediction is not adequately substantiated by research findings, and like so many areas in gerontology, conflicting results prevail. Kalish (1975) summarizes the outcome of studies suggesting "if older people have a reasonably stable recent history, an anticipated standard of living and no strong fears of being left alone, their self esteem rises with age. Conversely, when disruptive forces occur, when standard of living is well below the level of aspiration, and when fears of being isolated and alone are strong, the older person is more vulnerable." (p.5)

Physical appearance is important in determining one's self image. Apart from the occasional person whose face is judged to be interesting, the physical appearance of an older person is not usually seen as attractive and not as sexually attractive. Older people often make comments such as ...

When I look into the mirror I see the face of an old person, it isn't me - I have the spirit of a young person, or I am a prisoner of my body. It is not really me with arthritis, sagging breasts and a loose skin - it is someone else. (ibid. p.58)

1.5 Successful Patterns of Aging :

In the previous section, we have seen how aging brings with it many potentially negative effects which the individual has to come to terms with, if he is to adjust or adapt successfully. Some people manage to accept these changes quite readily whereas others break down, become ill and lose their independence. In this section we shall look briefly at what constitutes a healthy aging pattern.

The point is frequently raised that adjustment to aging often entails a negation of certain values and attitudes and a reversal of behaviour patterns which were well learned and rewarded throughout earlier life. The "adjusted" aged person must therefore adopt new ideas which are often in contradiction to many things he previously considered worthwhile, such as participation, independence and achievement. Furthermore, he must often reverse himself rather abruptly, and from the point of view of the adequately functioning individual, this is unjustifiable.

Aronson (1955) suggests that the person with psychological deficits from early life would be more likely to succumb to the stresses of old age than the person who was always psychologically sound. Greenleigh (1952) believed that the way an individual handles his own aging depends to a large degree upon attitudes towards old age which were formed early in life. Furthermore, he suggests that evidence favours better adaptation to the physiological changes on the part of persons who adjusted successfully to earlier life situations. Havighurst (1952) conceived of adjustment to old age as a developmental task of defensive character, involving adjustment to limitations, restrictions and deprivations of all kinds. Hollender (1952) has postulated that many of the unpleasant personality traits commonly associated with old age are reactions to loss of self-esteem. He suggested that the old person turns to the past, refuses to try new things, and becomes self-assertive and domineering as compensation for feelings of inferiority and inadequacy.

More recently, Kalish (1975) has identified four features of successful aging. These are (a) a way of life that is socially desirable for this age group, (b) maintenance of middle age activities, (c) a feeling of satisfaction with one's present status and activities, (d) a feeling of happiness and satisfaction with one's life.

Health is another feature which is crucial to how one ages. It is a central factor in every aspect of the older person's life. It cuts across every social, occupational and economic line to influence one's adaptive potential. The ability of an elderly person to adapt and thrive, is contingent on his physical health, his personality, his early life experiences, and on the societal support he receives. Failure to adapt at any age or under any circumstances can result in physical or emotional illness.

Currently there are two psychosocial theories which attempt to explain successful aging in the gerontological literature. Firstly, there is the disengagement theory which evolved from the Kansas City aging studies conducted by the University of Chicago's Committee on Human Development in the late 1950's. This theory postulated that older people and society mutually withdraw from each other as part of normal aging, and that this withdrawal is characterized by psychological well-being on the part of the older person. Two kinds of disengagement have been described.

- (1) Social disengagement, which refers to reducing the number and duration of social interactions, and

- (2) Psychological disengagement, which refers to the person's reducing the extent of his emotional commitment or involvement with these relationships and with what is going on in the world in general (Havighurst, Neugarten, & Tobin, 1968).

When the concept of disengagement was initially applied to the elderly, it was not only proposed as a descriptive theory, but also posited as an inevitable natural occurrence (rather than one imposed by other individuals or by social institutions and forces) and it was thought to be a positive, adaptive approach to successful aging.

One study of 250 older people (Maddox, 1963) showed that their morale was directly related to their level of activity. Furthermore, increased activity levels over time were predictive of increased morale, and decreased activity levels of decreased morale.

Out of this has come the current prevailing view that activity rather than disengagement produces the most agreeable psychological climate for older people.

The "activity theory" maintains that older people should remain active as long as they possibly can. When certain activities and associations must be given up, for example, employment, substitutes should be found. The older person's personality is a key element in shaping reactions to biological and social changes - an active rather than a passive role is important for mental health and satisfaction.

Work, no matter how odious an implication it may have for a person, is an enormously prized and meaningful experience to people. An activity, be it a job, interest or hobby, is part of the identifying data that every human being has. When one asks a man his name and address and where he comes from, the next obvious question is "What do you do?" This information gives one a frame of reference within which to operate. It provides for a structured situation in which both may feel comfortable. If the person one has asked has nothing to contribute, it strikes at the root of his self worth and self esteem.

Adjustment to aging forms a central theme of this thesis and hence will be discussed in great length at a later stage.

1.6 Stress, Disease and Behaviour :

In the previous sections, we have demonstrated that the effects of human aging are vast, and a function of many variables ranging from genetic

to environmental. Presently, we shall consider the more serious problems that occur in the latter part of the life cycle.

Busse (1969) has advanced two concepts to explain how one ages. The first, biological aging, refers to those genetic processes which are time-related but independent of stress, trauma, and disease. His other category, secondary aging, refers to the effects from trauma and chronic illness, and it is to this alternative that we direct our attention.

Biological theorists studying aging at the cellular and sub-cellular level, propose that cumulative effects of trauma to individual cells eventually result in organismic dysfunction. Curtis (1966) claims that there is increasing prevalence towards long term chronic disease, the etiology of which arises from cumulated insults to the organism. The immune system, a primary defence mechanism of the body, alters structurally with the passage of time. There is a decline in the protective mechanism, impaired surveillance and distortion in its functions resulting either in auto-destructive, or auto-aggressive phenomena. All these factors tend to shorten the life expectancy, and it is therefore apparent that with the passing of years, there is an increase in susceptibility to infection. Timaris (1972) outlines the criteria that are regarded injurious to the organism. It is his opinion that genetic changes, ionizing radiation, chemicals and toxins, mechanical and thermal events, a progressive accumulation of waste materials and stress have been regarded as producing many of the symptoms associated with chronic illness.

Bodily processes that formerly took care of themselves or required minimal attention, begin to demand more and more time as people age. Incontinence, and frequency of micturition cause much distress. Other common symptoms are insomnia, impotence, breathlessness, flatulence, obesity, and a tendency to fall. Pain is another frequent pre-occupation for the aged and is dealt with according to their life-style, personality

and cultural background. The use of drugs offers the most consistent relief, but can often produce side effects which can be particularly devitalizing or disorganizing.

Storr (1976) claims hospitalization after the age of 65 is often required for heart and circulatory diseases, digestive conditions and disturbances of the central nervous system. Buscoe (1967) claims that in young adulthood (up to 45 years of age), 35,3 per cent of all groups have one or more chronic conditions. "Between the ages of 45 and 64 chronic conditions are present in 61,3 per cent and limitations of activity in 18,3 per cent. From 65 years and over, chronic disorders advance to 78,7 per cent and disability to 45,1 per cent" (p.1128).

Being hospitalized generates many insecurities, as these institutions are not regarded as places to regain health, but are viewed as places to die as well. The emphasis on treating physical diseases, to the neglect of the more humane interactions with the elderly, combine to make them feel isolated, unprotected, lonely and bored. The restriction of mental and somatic activity encourages anxiety, irritability, disorientation and eventual regression.

Concepts of stress embrace as wide a gamut of human experience as do concepts bearing on human adjustment, which they are often called upon to explain. Clinicians traditionally attempt to pinpoint precipitating stresses, often defined as or perceived as acute; sociologists and social psychiatrists on the other hand have been concerned with environmental stress. The Leightons (1963) have distinguished between environmental and personally experienced stress, postulating that the former has the greater impact on mental health. Lowenthal (1967) has postulated a psychological explanation known as the "multiple stress theory" to account for the antecedents of psychiatric disorder in the elderly.

Briefly stated, impairment results from the accumulation of stress along the lifeline. The potential insults to the psyche are, widowhood, retirement, social isolation, decline in standard of living and physical illness or disability. Some peoples' lives are more stressed than others and with repeated stress over a period, adaptive strengths are taxed and breakdown may ensue. This theory pre-supposes that stress may accelerate the aging process over a given time, or it may lead to physical disease, which manifests as, or interacts with aging to increase degeneration.

Much opposition to this hypothesis arose (Kuypers & Benson, 1973) suggesting that many critical questions were left unanswered, namely, what constitutes stress? How does it accumulate? Where is it stored, and how do you measure it? These questions raised immense interest as to whether there was a causal relationship between predisposing stress factors, physiological correlates of stress, aging and associated impairments. Research has indicated that there has been little or no inter-disciplinary cooperation. Most attempts have included separate investigations with a multitude of definitions and to all intents and purposes, stress is a construct that remains vague and somewhat ambiguous. The multiplicity of approaches has not aided the confusion.

Behavioural responses in the form of anxiety, mal-coordination, fatigue, increased error rates, etc., have been operationally defined as indicators of stress and have been examined both in relation to (a) stress inducers, which vary from life crises (loss of loved one), change of style, cultural changes, frustration, failure, competition etc, and, (b) physiological changes induced by the endocrinological and nervous system.

Interactive sequences have been attempted, yet presently, the process by which stress (however initiated) in its transitory psycho-physiological form becomes a more permanent disruption characteristic of disease,

remains a tentative hypothesis (Eisdorfer & Wilkie, 1977). Lowenthal's stress theory used in consideration of mental disorder in the elderly only posits an association, but not the mechanism of causality.

1.7 Mental Illness in Later Life :

(a) Prevalence : Community study surveys, together with hospitalization rates, clearly demonstrates that older age groups have a substantial amount of mental illness (Kay et al, 1964). Prevalence rates of 10-20 per cent have been suggested (Shepherd et al, 1966). These high rates among the aged, coupled with the fact that an extremely high proportion (50 per cent) of hospital and nursing home beds in the United States are filled with psychiatrically ill elderly people, underscore the seriousness of this problem for the elderly (Stotsky, 1973). Psychiatric services have been largely confined to the institutionalized elderly, who now comprise two per cent of the 65-74 year age group and seven per cent of the 75 and over age group (Redick et al, 1973).

For these people the stresses and losses of aging have become too great and they are no longer able to cope with the demands of adult living. Many display symptoms, the causes of which are either functional or organic.

(b) Depression : A common clinical syndrome encountered in old age is depression. Affective disturbances, particularly depressions, are the most frequent functional psychiatric disorders in the later years (Busse, 1961). Depressions in this age group can vary greatly in duration and degree. Many elderly persons experience fleeting episodes of saddened affect, loss of energy and short-lived lack of interest, often in response to some adverse life situation or loss. Old age has been described as a season of loss, and depressive reactions are responses

to losses. The theme of loss is cited by a number of authors (Pfeiffer and Busse, 1973; Shock, 1962, and Kreps, 1969) to include inevitable decline in physical vigour, mental agility, income, loss of loved one, and finally, one's own impending demise. The ubiquitous nature of loss in this time of life may be one factor to explain the high frequency of depression. On the other hand, more severe and more lasting depressive reactions are experienced by substantially fewer elderly persons, again in response to significant losses in their lives or, more rarely, without recognizable precipitating circumstances.

(c) Neuroses : In spite of their clinical significance, neuroses in old age are largely ignored. According to Butler and Lewis (1977) ...

With neurosis there is neither gross distortion of reality nor profound personality disorganization, although thinking and judgement may be impaired. Neurosis represents attempts at resolving unconscious emotional conflicts and is characterized by anxiety. Probably most older people who develop neurotic symptoms had similar difficulties earlier in life. Neuroses are not inevitable in old age but are extremely common (p.60).

The incidence of all types of psycho-neuroses in the aged has been reported in the literature and these will be dealt with in greater depth at a later stage. Perhaps the hypochondriacal neurosis is the most common of all. It is substantially more frequent among older women than men, and it seems to increase in frequency with advancing age (Earley & von Mering, 1969). Hypochondriasis is characterised by excessive preoccupation with one's bodily functioning or by the concern that one has one or more specific diseases or diseased organ systems in the absence of significant physical pathology.

(d) Organic brain syndrome : The elderly are particularly prone to organic brain syndrome. The extensive epidemiological survey of old age mental disorder in Newcastle-upon-Tyne (Kay et al, 1964) estimated that 5.6 per cent of all the elderly over age 65 have chronic brain syndrome. People with this syndrome present the following symptoms: impairment of orientation; impairment of memory; impairment of intellect; impairment of judgement, and lability and shallowness of affect. The factors contributing to the organic brain syndrome are heart disease, low socio-economic status and inactivity (Busse and Wang, 1974). More specifically, a differential diagnosis of the following causes must be excluded: (a) congestive heart failure, (b) malnutrition and anaemia, (c) infection, (d) cerebrovascular accidents, (e) toxins, (f) head trauma, (g) alcohol, (h) metabolic deficiencies, and (i) senile dementia.

The following classificatory system has been undertaken to document mental illness in the aged: (a) the acute confusional state, (b) the chronic brain syndrome, and (c) the affective disorders.

It has not been the author's intention to give a detailed resume of the symptoms and etiology of psychopathology in the aging population, as this will be done in the appropriate section. Rather, the reader has been made aware of the many psychological changes occurring in the aging process. In summary, these are: decreasing cognitive abilities; feelings of loss; isolation; rejection; anxiety; frustration and restlessness. Collectively, these factors predispose the individual to risk of mental breakdown.

CHAPTER 2

‘Nothing is more dishonourable
than an old man, heavy with years,
who has no other evidence of having lived
long except his age.’

Seneca.



Institutionalization.

A Theoretical Perspective.

2.0 History :

In Britain, the early history of provision for the elderly was one of voluntary care, in which members of the church, following the teachings of St. Paul, gave precedence to the virtues of charity. Succour had to be given to the poor, the diseased and the destitute, not only as an end in itself, but for spiritual enrichment. Monastic infirmary almshouses represented the main provision for the elderly until the Reformation. When Henry VIII ordered the dissolution of the monasteries, numbers of the sick and infirm were made homeless and destitute. The Poor Law Act of 1601 placed the responsibility for care of the needy on each parish and for the next three and a half centuries, care was provided in a mixed workhouse environment in which young, old, blind, mentally ill,

sick and disabled people were cared for together. Gradually, the church workers and overseers acquired workhouses in which to provide 'indoor rather than outdoor' relief. Many of these became the seat of abuse and oppression and an attempt was made in 1782 to separate the elderly and disabled from the poor, the former group to be looked after in the workhouse, the latter given outdoor relief. Workhouses gradually developed infirmaries when it became clear that special accommodation was needed for those who were ill. The infirmaries soon became peopled with the aged and the chronically sick. However, conditions did not improve ...

"The fate of the 'infirm' inmates of crowded workhouses is lamentable in the extreme; they lead a life which would be like that of a vegetable, were it not that it preserves the doubtful privilege of sensibility to pain and mental misery. They are regarded by the officials connected with the establishment as an anomalous but unavoidable nuisance".

(Brocklehurst, 1975, p.7)

This attitude has been maintained until recently. Invariably, the aged have been at the end of the queue for resources, partly because of society's general attitudes to aging, partly because of the low value and status accorded to work performed by older people, and partly because the elderly themselves often accept a low self-evaluation and are inclined to make few demands.

Despite the changes brought about by medical science in which more resources were made available to the elderly, the general attitudes to the aged were, and still are, imbued with negative stereotypes. Culture defines and influences the social processes

of aging by which society deals with the aged and the rendering of services to them. Theories of institutional care of the aged within the total society reflect the attitudes and the values of that society.

Not only was the institution the sole resource, but the "indigency" philosophy set the standards for design and care. The older person -- the inmate -- had to be protected. He was, usually, financially indigent without a family and homeless. He accepted the role and expected to be a second-class citizen, resigned to regimentation, a meagre diet, drab uniform clothing, shared accommodation in barrack-like wards, and subordination to those in whose care he was placed. He was the recipient of someone else's charity and subject to the abuses inherent in a sharp division between inmate and staff worlds.

Emphasis was placed on meeting physical needs, providing clothing, food, and shelter, with religious observances added for spiritual needs. The institutional staff were in general, geared to an asylum type of philosophy, giving custodial care to inmates en masse.

Speaking of the early development of services for the aged in American Society, Shore (1969) claims that there were not large numbers of aged in society. There was no national or governmental concern for, or interest in the aged, and local support prevailed. Facilities were not planned on a community basis but resulted from a trial and error approach to the provision of these services, usually embodying a separate and sometimes equal policy of serving the aged, the infirm, and other categories of the poor. The opinion was held, if not expressed, that the poor were a species of the unfit and should not be pampered or coddled. Above all, facilities and care

were not to be luxurious. What was provided for "them" was "good enough" and the poor including the aged, should accept and be grateful for efforts on their behalf.

As institutions evolved, their uses and sponsorship changed but the model remained. Thus even the privately-sponsored, church-supported homes created a series of rules and regulations that made institutional life undesirable.

In recent years however, a new concept or philosophy of institutions for the aged has begun to emerge. As life expectancy and longevity increase, the institution serving the aged becomes a more significant resource. Social scientists have studied the characteristics and nature of institutional life to achieve a greater understanding and recognition of the complexities of institutionalization. The institution is seen as a social system, an organization and a community. There is increasing interest in the needs, capacities and problems of the aged, and communities are seeking solutions to these developments by expanding both institutional and non-institutional services. Changes in the health and financial circumstances of the older person also present new and greater challenges to long-term care institutions.

2.1 What Characterises An Institution :

Residential institutions, whether hospitals, prisons or old age homes, have an internal life of their own: each institution has an organized social system which is maintained by all those people who function within it. In this section we shall consider the meaning of institutional life, with particular reference to both the society

and the aged resident.

(1) The Meaning of Institutionalization for Society :

Research evidence supports the theory that as the number of old people increase in western societies, so there is a growing tendency to increase the rate of institutionalization (Fisher, 1953; Kolb, 1956; Lissitz, 1970). Recent studies (Granick & Zeman, 1960; Granick & Nahemow, 1961; Tec & Granick, 1960) have noted the relationship between the growing trend toward institutionalization of the aged and their enforced isolation in the community. Taking Simmel's (1955) idea of the social system and applying it to the geriatric population, one possible hypothesis states that institutional care reflects the conflicts within society over the aged. Policies and practices in the care of the aged are not systematized and are not part of a social system. Conflicts exist, are important, and disfunction is at work. Institutional care may be regarded as the ultimate in disengagement and withdrawal of the aged from society. This extreme isolation of aged individuals may represent a potential threat to the community in the form of fire and health hazards (Bennet, 1963). Difficult aged persons are forced into institutional settings as a means of controlling them.

The alternate view is proposed by Talcott Parson's understanding of the social system. The present social processes, norms, expectations attitudes and goals are seen and considered as functional and mainly effective in handling the challenges of longevity. The structure and function are supposedly aligned and synchronized, therefore the

social system is regarded as being in equilibrium. All groups within the social system, including the aged, are supposedly in balance. Since the physical, economic and social losses are unavoidable at this stage of the life cycle, many aged individuals enter institutions voluntarily.

(2) The Sociological Meaning of Institutionalization :

Goffman (1961) has made a very important contribution to the sociological study of residential institutions as organizations in terms of their caring functions within a wider society. In *Asylums*, he suggests that institutions have an encompassing, total character which is symbolized by barriers to interaction with external society. Often, he contends, these barriers are built into the structure of the institution in the form of high walls, locked doors, etc., but they may equally be implicit in other restrictions on departure and outside contacts.

His concept of the total institution has several central features:

- (1) All aspects of life are conducted in the same place under the same single authority.
- (2) Each phase of the member's daily activity will be carried out in the immediate company of others, all of whom are treated alike and required to do the same thing together.
- (3) All phases of the day's activities are tightly scheduled, with one activity leading at a prearranged time into the next, the whole circle of activities being imposed from above through a system of explicit formal rulings and a body of officials.
- (4) The contents of the various enforced activities are brought

together as parts of a single rational plan, purportedly designed to fulfil the official aims of the institution.

(Goffman, 1960, p.450).

He lists the total institutions in our society in five rough groupings. These are 1) for persons incapable and harmless e.g. homes for the blind and the aged; 2) for persons incapable and socially threatening, e.g. tuberculosis sanatoria and mental institutions; 3) those which protect the community, e.g. prisons and concentration camps; 4) those for the pursuit of technical tasks, e.g. army barracks; and 5) retreats, e.g. monasteries and convents. (ibid, p.453). It should, of course, be borne in mind that Goffman was dealing with the ideal type, and individual institutions must be viewed with rather more flexibility.

Some of these generalised ideas can be applied to long-term care for the elderly and the negative connotations should be examined.

(a) Ritualisation and standardisation: A lack of staffing resources is commonly given as the reason for having a fixed schedule for task performance. Domestic staff in an old people's home follow a rigid program to fit in their cleaning duties before giving out the morning drink. Residents cannot use a sitting room until after the carpet has been swept at 9.00 a.m. every day, visitors can only be entertained on the sun porch etc. etc., examples are numerous.

(b) Rigidity and inflexibility: This is by no means restricted to staff behaviour patterns. Many residents insist on having their own chair in the lounge and dining room. Any violation of their territorial rights is greeted with strong reactions. Individual privacy is restricted by physical factors (bedrooms in residential homes with several beds) and the need for fixed points in the individual's life emphasizes

the tendency to ritual and inflexibility. Block treatment - treating all those who live in the institution in the same way - reduces individuality and lowers self-esteem. This too emphasises the need for some personal possessions - the security of a personal chair, a private corner, etc.

(c) Social structure of the home: The Home consists of two mutually exclusive and differentially ranked systems: the staff system and the resident system. While the staff sets the tone of and limits the behaviour among residents, it is nevertheless dependent on active resident participation in order to carry out many required functions. The Home actively seeks the resident's cooperation. Residents in turn acquire differential status in the system, depending on such factors as length of stay, sociability, and jobs performed. Despite the mutual need for each other, a process of stereotyping often takes place which includes feelings of hostility between both groups. From the staff point of view, this involves feelings that residents are rejecting help, and are often bitter and uncooperative. Patients and residents frequently feel guilty, anxious, vulnerable and afraid of the power of staff members. One response to this split is depersonalisation which takes the form of denying recognition to the individuality or wholeness of the resident. Many homes and hospitals can be seen to be full of clean, well-fed bodies but not of people.

(d) Role-deprivation: is a consequence of growing old, entry to an old peoples home or hospital will involve role loss ...

Those who go into an enclosed environment leave behind them many active roles; they stop being people who pay the milkman or who hold their own rent book and collect their own pension. The loss of all these roles and reciprocal relationship that they imply at a time of other major life changes, adds up to considerable personal deprivation.

(Brearley, 1977, p.18).

(3) The Meaning of Institutional Life to Residents :

Bennett (1963) claims that the following are explicit statements of some implicit resident norms:

- (1) A resident should neither criticise The Home nor complain about it.
- (2) Not only should he not criticise The Home, he should praise it and come to accept it as his home.
- (3) A resident should keep active and busy.
- (4) A resident should not argue with others in The Home. If possible he should avoid intimate contact with others and only observe formalities, which consist mainly of saying "good morning" or "good evening". (p.22)

Many old timers voluntarily greet newcomers as well as visitors to The Home and will gladly spend time singing its praises ...

Since there are no circumstances in The Home under which newcomers are segregated from old timers, as is the case in colleges or the armed services, for example, old timers play a vital role in acquainting newly admitted residents with normative patterns. This undoubtedly accounts for the rapidity with which most residents learn what is expected of them (ibid, p.123).

It is only after a few weeks of residence that the full impact of the meaning of adjustments to institutional life occurs. It is at this juncture that new residents frequently begin to re-evaluate their decision to enter the particular home in question and complain about having to adjust to difficult room-mates or simply to the fact of sharing a room. They discover that they are becoming progressively insulated from the

outside community and they often complain that they have been forgotten. With time, however, most new residents find that they are responding to the demands of institutional life and the wishes of staff members and their fellow residents. Over a relatively short period, many new residents internalise the value structure of the home and come to the conclusion that the demands made upon them are justified and reasonable. The question of adjustment to aged homes will be the prime focus of this particular study and will be dealt with in greater length in the following chapter.

2.2 Institutional Care and Dependency :

Sorting out dependencies due to advancing age - that is, those intrinsic to the very processes of aging - from those due to the psychological, social, and physical environment, is a task that has been a focus of research and practice since the inception of scientific and professional interest in aging. Though knowledge is far from complete, it appears that the interactive standpoint is the most sensible. Certainly there is abundant evidence that a significant amount of the dependencies of older people is environmentally induced. Likewise the general direction in old age is a decline in the level of functioning. Physiological and disease-related changes are part of aging that lead to dependency.

Recognition that some decline is inevitable compels re-examination of the value judgement often implicit in attitudes towards dependency - specifically, the notion that dependency per se is "bad" and independence is "good". Though the number and nature of supports required vary over time, normal, healthy inter-dependence is a constant throughout the life-span. Beginning with total dependency in infancy, as the

individual moves through childhood and adolescence and gains competence, he assumes more and more responsibility for himself; with maturity he assumes a care-giving role towards others. In the aging phase of life he again may become more dependent. This time, the goals of chronic care are different. The dependencies of old age are chronic rather than transitional; they may foreshadow continuing or increasing dependency. Chronicity dictates that supports provided on any level aimed at maximising dependence, must be sustained.

The series of stresses that have been called the "insults" of aging contribute to dependency. Unique to this phase of life is the occurrence of intrinsic and socially induced stresses coming at a time when the individual's coping capacities are diminished: the loss of physical and/or mental capacities; loss of income, employment, and status; interpersonal losses of spouse, other relatives, peers, and the special poignancy of loss of adult children.

Many aged persons transfer their dependency needs on to their children, who are then required to care for them. "The strong and comforting people who once nurtured you are now in need of your strength and comfort. The roles are reversed. Your parents now seem like your children: dependent, demanding, needing more, perhaps, than you can give." (Grollman & Grollman, 1978, p.4). In cases where the nuclear family cannot take on added pressure, aged individuals become eligible for admission to residential institutions and homes. These facilities provide care and attention which is not otherwise available to them. Institutional care therefore includes any care (medical, psychiatric, or social) given to older people not residing in their own homes or the homes of family or friends. Early research (Martin, 1955) has suggested that health, marital status, income and residential stability were closely related to the institutional decision. In general, poor

health and low income coupled with the loss of spouse and home, were primary forces accounting for the move from an independent to a dependent existence. Elderly people who enter long term care institutions do so to assure survival by retarding further deterioration, maintaining residual capacities, and restoring lost functioning.

In one form or another, dependency manifests itself within the aged persons both in the community and in the geriatric facility. It gives the aged serious misgivings, fears, and guilt feelings. Most aged persons react with guilt to their need to have others help them with their activities of daily living. Dependency involves a reversal of roles by the aged living within either geriatric institutions or in the community. Their self-image and self-esteem are often damaged. Furthermore, questions about individual worth and personal autonomy arise. Lifton (1967) has identified aggressive behaviour present in the dependency of many people. Persons in a subordinate position require their needs to be met, but are distrustful of "counterfeit nurturance". The person wants his dependency needs satisfied but he suspects the sincerity and goals of the individual assisting him. Aged citizens want to be certain that condescension and paternalism are not present. In the final analysis, the author is in agreement with Goldfarb (1969) who suggests that a particular personality type, the dependent personality, is more likely to seek institutional care.

2.3 Characteristics of The Institutionalized Elderly :

Gottesman & Hutchinson (1974) claim that ...

Of all persons 65 and older, the 1970 census shows that only one in twenty is in an institution. Although it is estimated that the

proportion of the population 65 and over will increase by only 0,3 per cent in the next fifty years the number of people in institutions will double. If the present rate of institutionalization continues, the problems of institutional care for the elderly will remain a serious concern. (p.30).

There are two major reasons why people are in institutions. First, they are likely to be suffering from one or more disabling chronic conditions. Second, they are likely to lack the psychological, social and/or economic means for dealing with their condition outside an institution.

When looking at the disabling conditions of institutionalized people en masse, we find both mental and physical disorders are exceptionally prevalent. The most common psychiatric condition is the organic brain syndrome, the etiology of which results from arteriosclerosis, senility, or the effects of drugs, alcohol or syphilis. There are a few suffering from mood disorders and a high proportion of chronic schizophrenics who frequent nursing homes or the back wards of the State Mental Hospitals. Many patients have other conditions, either alone or in combination with mental disorder. The most common of these are heart disease, stroke, or speech disorders associated with stroke - all disorders of the circulatory system. Next most common are disorders affecting the skeletal system, namely, paralysis not due to stroke, back disorders, physical deformity and arthritis. Finally, a smaller number of patients suffer disorders of the digestive system. Even though the large proportion are not seriously disabled, at least a half, get help with activities of daily living.

According to Goldfarb (1962) a wide variety of older persons need protective care in a congregate living arrangement that provides a therapeutic milieu. Included are persons from 65 to over 95 years of age,

of varied ethnic, religious, cultural, occupational, and socio-economic backgrounds, who differ in terms of availability of supportive family members, friends and other personal resources, as well as in energy, interests, types of illness and physical and mental functional status.

The group of elderly patients in mental hospitals, nursing homes and homes for the aged, differ from the community aged in several ways. They are more likely to be older, to be women, and to be unmarried or widowed. Looking at these traits and the more common diagnoses, we suspect that many elderly patients in long term care settings are people who lack stable community resources to take care of them and whose disabilities require a considerable amount of attention. Women represent a somewhat larger proportion of elderly mental patients than they do of the elderly in the general population. Women are an even larger proportion of the nursing and aged home population at every age. Since at every age females have a longer life expectancy than men, they have a greater chance of being ill and alone. Men in the various homes are, on the average, somewhat younger than the women. They are less likely to be widowed than female patients, but somewhat more likely to be divorced or never married. In general, men are somewhat more likely than women to enter a nursing home for functional mental illness, stroke or paralysis. Because they are younger, they are somewhat less likely than women patients to have advanced senility, arteriosclerosis, arthritis, or physical deformity.

The argument we are developing is that one is more likely to be in an institution if one does not have a family which can provide care. At every age, single people are much more likely to be institutionalized than others their age. Divorced, and separated people are also more vulnerable, and even the widowed are somewhat more likely to enter a mental hospital, nursing home or aged home. On the other hand, people

who have intact marriages are, at every age, much less likely to become institutionalized persons. In the case of the unmarried and widowed persons, there is an absence of anyone to care for them if they become ill. The poverty of the institutionalized aged is suggested by several factors. First, it is general knowledge that the elderly live on fixed incomes. What savings they have acquired over a life span are likely to be diminished by inflation. When illness occurs, high medical costs rapidly erode their financial resources and placement into an institution is precipitated.

2.4 Types of Geriatric Institutions :

In each culture and each country, people develop their own ways of caring for the elderly. Reader (1973) claims ...

Institutions in the United States for medical care of the elderly constitute a spectrum based on intensity and complexity of care that includes, home care, day care, day hospitals, infirm care in homes for the aged or retirement communities, nursing homes, extended care facilities, chronic disease hospitals and terminal care homes, and other speciality hospitals, and acute general care hospitals. (p.290).

From the above, we can conclude that there are both short and long term types of institutional care available to the aged. Acute hospitalization usually applies to hospital stays lasting from a few days to three months, during which diagnosis and treatment take place simultaneously. Aside from urgent physical pathology which needs attention, the main type of mental symptoms presented on admission are transient confusional states and functional disorders.

Chronic hospitalization patients are admitted because of organic brain damage. Persons with chronic physical conditions (e.g., C.V.A. victims) may be admitted to chronic disease and geriatric hospitals, even though such persons have accompanying or previously existing mental problems. It can be argued that inmates of a mental institution who present with the organic brain syndrome need not be there, since nursing homes and other facilities could provide the appropriate care. Stotsky (1967) postulates that many older people are in mental hospitals, not because they need to be there, but simply because there is no other facility for them.

The other facilities the aged folk make use of are nursing homes, and homes for the aging. The latter are voluntary, non-profit institutions, run under the auspices of religious, benevolent, and fraternal associations, or trusts. Many are selective in their admission, and persons without some wealth and a sustaining family are more likely to be rejected. Most aged homes ordinarily exclude the overtly mentally ill, the severely mentally impaired, and the acutely or notably physically ill.

However, there are those who are in need and who could be served in a manner that would allow them to remain in, or be returned to, their communities where life would be more acceptable to them and to all of us who on the one hand feel threatened by the same ravages of time and who feel guilty in excluding them from communal life and participation. Comprehensive community based mental health services for the mentally ill and the aged is one of the answers to this vexing problem.

Presently, in the United States, large numbers of people are being released from large institutions and placed in smaller institutions situated within the community but where the care is not individualised. In essence, therefore, nothing has changed. What is optimistic, however,

is the fact that the past several years have witnessed a vast public awareness of the needs of the aged. Considerable research has been originated within universities, and state and voluntary agencies in an attempt to establish new knowledge and effective technologies for serving the elderly. To a large extent the traditional beliefs and myths about the elderly have been overcome and organizations are making a more rational attempt to provide more viable public and voluntary services.

In Western Europe and North America, the elderly are becoming a political force that is certain to mould public policy in future years. Once the elderly are recognized as an important political social force, services and programs will emerge not "begrudgingly" but as a rational response to our temporary lapse in humanity. The above attitude has important implications for the development of better care facilities for the institutionalized aged population. Ideally, if it is to be properly and flexibly utilised, the in-patient care of persons who need help from social institutions (because of physical decline, mental impairment, and disturbed or disturbing behaviour) should be part of a larger, integrated comprehensive care system. For all, the milieu should be protective and emotionally and psychologically supportive.

2.5 The Effects of Institutionalization :

The effects of institutionalization on adult patients of mental hospitals have received much attention lately. Reviewing the many studies on the effects of mental and other institutions, Sommer & Osgood (1961) classified institutional effects into six general symptoms: (1) deindividuation, a reduced capacity for thought and action as a result of dependence on the institution; (2) disculturation, the

acquisition of institutional values unsuited to the previous or pre-admission environment; (3) emotional, social, and physical damage to the resident from losses of status, security and so on; (4) estrangement from the consequences of technological and other changes in the outside world; (5) isolation through loss of contact with the outside world and (6) stimulus deprivation, a result of the senses being deadened by prolonged institutionalization. This classification was based on findings of studies that usually compared short and long term patients. As the authors caution, selective discharge of the better functioning patients could very well have led to an overestimation of institutional effects.

The symptoms of institutionalized mental patients are not unlike the symptoms in studies of the elderly residing in homes for the aged, domiciliaries and nursing homes. A review of these studies (Lieberman, 1969) suggests that institutionalized elderly share the following characteristics: poor adjustment; depression and unhappiness; intellectual ineffectiveness because of increased rigidity and low energy (but not necessarily intellectual incompetence); negative self-image; feelings of personal insignificance and impotence; and a view of self as old. Residents tend to be docile and submissive; to show a low range of interests and activities, and to live in the past rather than the future. They are withdrawn and unresponsive in relation to others. There is some suggestion that they have increased anxiety, which at times has their own death as a focus.

Townsend (1964) described unsatisfactory physical conditions in many homes for the elderly and commented on petty restrictions and authoritarianism still prevalent. Whitehead (1970) gives the following description of the conditions in certain homes for the aged:

... Conditions in backward institutions are such that the most inexpert observer can see there is something wrong. Patients are herded together in old, bleak, neglected buildings with long dark wards, closely placed rows of beds, little furniture and frightening inactivity. Multiple regulations curtail the patient's freedom and reduce their contact with the outside world. They may be confined to the ward and allowed out only in large supervised groups. Privacy, unusually valued by the elderly, is often non-existent. Bathing is supervised and may take place in a communal bathroom. Visiting is restricted to a few hours per week and children are often prohibited. To visit some wards for the elderly is to visit the annex to the mortuary. Rows of old people lie in bed with legs bent and muscles wasted by lack of use, eyes dull and vacant, waiting to die. (p.24).

Barton (1959) has described symptoms of an illness experienced by people living within institutions which he calls 'institutional neurosis'. This is caused by elements within the institution, particular loss of contact with the outside world and complete submersion in the institutional system. Institutional neurosis may occur in all kinds of institutions - prisons, hospitals, monasteries and residential homes. Loss of contact with the outside world, and erosion of the personality by the overpowering control exerted by the institution are important factors in the production of this condition. The inmate becomes over-dependent, does what he is told because this is the only way to avoid trouble, loses initiative and interest and becomes one of a group of automatons. His appearance often demonstrates the effect the institution has had upon him: his face loses much of its expression, the head is held slightly bowed and the arms held semi-flexed with the hands closed.

Old people seem particularly vulnerable to institutional neurosis which is associated with the negative elements of enclosed life which have already been described. Whitehead (1970) suggests that three factors tend to perpetuate these conditions. He blames the lack of satisfactory motivated staff, the fact that the staff are often poorly trained and ignorant of the emotional needs of the elderly, and the problems of authoritarian hospital regimes which produce petty restrictions and staff fears.

In these circumstances it is hardly surprising that some older patients respond to pressure by sinking into withdrawal and deny the reality of their existence. Seligman (1975) claims that institutional systems are all too often insensitive to their inhabitants' need for control over important events. Lack of control produces helplessness and concomitant depression. An initial attempt to hide from the world becomes habitual and is made more rigid by the over-protection often found in nursing care of the elderly.

Institutionalised patients, whether in terminal cancer wards, leukaemic childrens' wards, or old age homes, should be given maximum control over all aspects of their daily lives: choice of omelets or scrambled eggs for breakfast, blue or red curtains, going to the movies on Wednesdays or Thursdays, whether they wake up early or sleep late. If the theory of helplessness set forth here has any validity, these people may live longer, may show more spontaneous remissions and will certainly be much happier (ibid, p.183).

Considerable research and 'journalistic muckraking' has served to portray the plight of the elderly in institutional settings. Unfortunately, there are a number of commonly held beliefs about persons who have reached, or appear to need, institutional care in their old age. Some of these incorrect ideas can be summarized as follows ...

"Aged persons in our society are rejected and neglected and discriminated against. They are discarded by selfish, callous families and are relegated to loneliness and discomfort, which affect their mental and emotional well-being. When they become ill they are quickly dumped into state hospitals, nursing homes, or old age homes, where many of them die from the shock of transfer or from humiliation. Large numbers of them are forced to remain in institutions simply because they have no place to go, and this is largely because their place in the community has been permitted to close in behind them (Goldfarb, 1977, p.290).

In the final analysis, these seemingly compassionate remarks about the position of the institutionalized aged, are actually misstatements that tend to confuse thought and to block social action. There is significant evidence that institutional residents can improve their physical, psychological and social functioning.

CHAPTER 3

‘The dirty
dog-earned back of the day,
like a card passed from the deck,
lies on the lake,
and its two-spot eyes
stare at the sky
but take in no trick.’
Anon.



The Effects of Institutionalization.

Research.

3.0 Studies That Have Examined The Effects of Institutionalization In The Aged :

To live to an advanced old age may indeed be a blessing but in many circumstances it may well be a curse. We have demonstrated that living through the seventh, eighth and ninth decades of life can bring both personal deterioration and social losses. When less drastic efforts to adapt to these misfortunes fail, the elderly person and his or her family are often forced toward the more drastic solution of seeking institutional care. With each advancing year, the older person becomes increasingly aware that a catastrophic illness or a major loss in the social support system may necessitate this dreaded possibility.

The effects of institutionalization on the psychological well-being and integrity of aged adults has been a question of humanitarian

interest since the late nineteenth century and of scientific inquiry for thirty years. These recent inquiries have drawn heavily on the body of socio-psychological knowledge associated with the effects upon individuals (of all ages) living in institutions for prolonged periods. The institutions may be orphanages, boarding schools, cloisters, army barracks, concentration camps, hospitals and old age homes. The examples mentioned all display features of what Goffman (1961) calls, "the total institution" i.e., whole groups of people, separated from the wider society for a long period of time, that lead an enclosed life, collectively regimented by a formal organization of a few. A variety of terms, usually negative in connotation, have been used to describe the different socio-psychological phenomena underlying the effects of living in institutions such as "institutional dependency" (Coser 1956; Straus, 1951), "mortification and curtailment of self" (Goffman, 1961), and "depersonalization" (Townsend, 1962).

The literature is replete with descriptions of the institutionalized elderly as disoriented, and disorganized, withdrawn and apathetic, depressed and hopeless. ...

In the institution, people live communally with a minimum of privacy and yet their relationships with each other are slender. Many subsist in a kind of defensive shell of isolation. Their mobility is restricted and they have little access to a general society. Their social experiences are limited and the staff lead a rather separate existence from them. They are subtly oriented toward a system in which they submit to orderly routine, non-creative occupations and cannot exercise much self-determination. They are deprived of intimate family relationships and can rarely find substitutes which seem to be no more than a pale imitation

of those enjoyed by most people in a general community. The result for the individual seems fairly often to be a gradual process of depersonalization. He has too little opportunity to develop the talents he possesses and they atrophy through disuse. He may become resigned and depressed and may display no interest in the future or in things not immediately personal. He sometimes becomes apathetic, talks little and lacks initiative. His personal toilet and habits may deteriorate. Occasionally he seems to withdraw into a private world of fantasy. In some of the smaller and more humanely administered institutions, these various characteristics seem to be less frequently found, but they are still present. (Townsend, 1962, p.328-329)

The institution, in other words, is perceived as a coercive force often causing more incapacity than it cures.

Much of the above evidence has arisen from studies which compare the institutionalized aged with those who reside in the community. The institutionalized aged tend to view the self more negatively than do community-living aged (Laverty, 1950; Lieberman and Lakin, 1963; Pollack et al, 1962; Webb, 1959). Moreover, the institutionalized group is less well adjusted, more docile and submissive, more isolated, has lower energy output, less drive and spontaneity, and is less outgoing and emotionally responsive than the community group. (Pan, 1948; Davidson and Kruglov, 1952; Ames et al, 1954; Davol., 1958; Lakin, 1960). In relation to orientation to time, the institutionalized groups seem to be more concerned with the past, whereas community groups are more interested in the future (Fink, 1957; Laverty, 1950).

A review of these studies suggests that institutional elderly residing in homes for the aged, domiciliaries, and nursing homes share

the following characteristics :

... poor adjustment, depression and unhappiness, intellectual ineffectiveness because of increased rigidity and low energy (but not necessarily intellectual incompetence), negative self-image, feelings of personal insignificance and impotency, and a view of self as old. Residents tend to be docile, submissive, show a low range of interests and activities and to live in the past rather than the future. They are withdrawn and unresponsive in relationships to others. There is some suggestion that they have increased anxiety, which at times focuses on feelings of death (Lieberman, 1969, p.330-331).

These studies imply that aged persons residing in a variety of institutional settings are psychologically worse off and likely to die sooner than aged persons living in the community.

Contrary to the findings of the studies reporting only negative consequences of placement in an old age facility, Lieberman, Prock and Tobin (1968) found both beneficial and detrimental effects upon being institutionalized. They compared elderly individuals in three groups: those who had resided in one of two Jewish homes for the aged for one to three years; individuals on the waiting lists for the two homes; and aged individuals residing in the community who would be likely to seek care from these homes if they experienced a crisis that warranted it. The subjects were compared on cognitive function, body orientation, personality traits, self-image, time perspective, affect and interpersonal relationships.

The results indicated that the three groups were not significantly different in terms of interpersonal relationships, self-image, or

personality traits. Compared with the non-waiting list subjects in the community, the institutionalized subjects were significantly poorer in cognitive functioning, were more preoccupied with their bodies and health needs, evidenced more negative affect, and showed poorer time perspective. Subjects on the waiting list, however, differed significantly, in a negative direction, from the non-waiting list community subjects on each of these variables except cognitive functioning. In addition, they experienced more anxiety than did the non-waiting list community or institutionalized groups.

Comparisons between subjects on the waiting lists and institutionalized subjects indicated that the institutionalized subjects were psychologically healthier, particularly in terms of lower levels of anxiety and depression, demonstrated a better overall affect, and had better interpersonal relationships. Lieberman et al (1968) suggested that this difference may be due to an amelioration of the crises-related reactions encountered during the waiting list period.

The question theorists have raised is whether living in an institution causes these effects, or whether entrants coming to an old age home, nursing home or hospital are a distinct population, different from those in the community. Goldfarb (1969) argues that a particular type of older person, the dependent personality, is more likely to seek institutional care. If this type of person, in addition, is more likely to react adversely to living in an institution, then the greying portrait of the institutionalized elderly is partly a product of selection bias. Clearly then, institutionalization is not the only variable creating the difference. Before such a conclusion can be entertained, aged persons living in institutions and aged

persons living in the community must be shown to be comparable, differing only in respect of where they live. It must also be shown that the characteristics of institutional life, per se, and not other factors associated with becoming institutionalized, induce these deleterious effects. How many of the effects attributed to living in institutions can be explained on the basis of population differences between those living in the community and those residing in institutions? It would appear that the differences between the two groups as highlighted by research studies are often influenced by the factor of selection.

The reasons why people apply for admission to live in an institution are by no means clear. As we have mentioned, Goldfarb (1969) hypothesized that it is a dependent type of person that seeks institutional care. Physical, psycho-social and economic losses have predisposed institutional populations to being more vulnerable and according to Lieberman & Tobin (1976), older people who seek institutional care are those who are deteriorating more rapidly than others. Lowenthal and Haven (1968) have offered another explanation for those who become institutionalized. They found the lack of a confidante to be a critical variable in the admission of elderly patients to the state mental hospital.

3.1 Attitudes Associated With Admission To An Institution :

A quite different explanation, independent of selection bias, suggests that the factors that cause noxious effects are set in motion by the process of becoming institutionalized. The losses associated with moving to an institution may be experienced before the actual move. Separation may become final after entering and living in the institution, but discussions of the move and application to a home can certainly

lead to feelings of separation from and rejection by family members, who have been involved in the decision (Hacker & Gaitz, 1969). The prospect of placement of an older person in a long term care facility and the application process itself, are critical psychological experiences for the elderly individual and family members in each generation. A definite family life crisis is precipitated at this juncture ...

Elderly people shudder at the thought of institutions, as do their children. Institutes are reserved as the last recourse after everything else has been tried, and families will go through unbelievable hardship before giving in to placement (Butler, 1977, p.123).

When long-term care is being considered, the degree or intensity of stress may vary but feelings are mixed and family relationship patterns are revealed vividly. The elderly person may be in a state of intense anxiety and fear. Even if family relations are basically warm and healthy and he/she recognizes the necessity of placement on a reality level, psychologically he/she still experiences some feelings of abandonment and rejection. For the adult children (and other relatives including spouse or siblings), guilt, conflict, and shame may coexist with the conscious or unconscious but very human desire to be relieved of burdens they have carried out, often beyond the saturation point. These feelings of ambivalence may force relatives to stop visiting the aged person once the process of institutionalization has taken place.

Several studies have examined attitudes of the aged toward institutional care. Kleemier (1961), for example, suggested that older people exhibit a generalized negative feeling toward all special settings

for the elderly. Shanas (1961) believes that almost all older people view the move to a home for the aged or to a nursing home, with fear and hostility. In their opinion, it is the final prelude to death and on almost all occasions the aged feel rejected by their families. On admission the elderly person is in a state of personal crisis, having left his own home, furniture and to a large extent, his identity. He will have been deprived of roles and status and generally feel unwanted, worthless, strange and confused. Montgomery (1965) who studied rural elderly, found a consistent desire to remain in their present residence and equated this desire with highly valued independence. Lieberman & Tobin (1976) claim to see the move to a long term care institution as a prelude to death. This is not unrealistic, given the age of older people who enter these institutions and given the fact that an old aged home will probably be the setting where death will occur for many of the frail and deteriorated elderly.

The decision to institutionalize a loved one is among the most difficult anyone is ever required to make. "A nursing home? How can I do this to them?" When a parent hears that the family are considering institutionalization he/she might say ...

What are you doing to me?

A nursing home?

So you can wash your hands of me?

After all I've done for you.

You promised you would never put me in one of those places

(Grollman & Grollman (1978) p.115)

The above quotation represents the fear and trepidation with which the aged person views institutionalization. These types of responses support earlier findings that institutionalization is a dreaded event.

If one starts out with such a 'negative mental set', one's adjustment to, and course in the institution is likely to be difficult and at times extremely painful.

3.2 Effects Due to Environmental Change :

With the advent of urban renewal, debilitating physical decline, or decreased financial resources, aged individuals often find relocation a necessity. As a result, the effects of relocation on the aged have been studied frequently in recent years, yielding often contradictory results. Many researchers (e.g. Lieberman, 1961; Aldrich & Mendkoff, 1963; Killian, 1970; Markus, Blenker, Bloom & Downs, 1972) have found that relocation has negative effects on the aged (e.g. increased mortality, depression, decreased activity levels). Others have failed to find debilitating effects attributable to relocation (e.g. Carp, 1968; Lawton & Yaffe, 1970; Miller and Lieberman, 1965; Wittels and Botwinick, 1974).

Relocation is defined as a life event which represents a major change in the lives of most individuals (Dohrenwend & Dohrenwend, 1974). Recent developments have directed attention to the importance of life changes as a determinant of the overall health status of the individual. In general, it appears that significant life changes are stressful and these exact a price both psychologically and physically from the individual who experiences them (Lowenthal, 1967; Aquilera and Messick, 1978; Golan, 1978). Research has indicated that one of the most important parameters contributing to relocation stress in the aged is the lack of control. Personal control is defined as the ability to manipulate some aspect of the environment. Averill (1973) distinguishes three types of personal control - behavioural, cognitive, and decisional - and

points out that each can be beneficial in alleviating the negative effects of a stressor. The greater the choice the individual has, the less negative the effects of relocation. Thus voluntary relocatees should fare better than involuntary relocatees.

A study by Ferrari (1963) illustrates how decisional control contributes to differential patient outcomes. Two groups of aged individuals were compared, one entering an institution voluntarily and the other having no alternative. Those with no choice had a much higher mortality rate than those with choice. Shrut (1965) investigated the effects of location on two groups: one from home to traditional institutional housing and the other from home to an apartment house for the elderly. It was not surprising to find that individuals who moved to institutional housing were more afraid of, and preoccupied with, death, less socially alert, less productive and less cooperative, than other relocatees.

Shultz & Brenner (1977) have advanced the following hypothesis :

The more predictable a new environment is, the less negative the effects of relocation. To the extent that an individual is prepared for a new environment through, for example, educational programs or counselling, he should be less adversely affected by relocation than an individual who is not prepared. In the absence of a preparatory program, predictability should vary as a function of the severity of the environmental change. Thus a move from home to an institution should be more devastating than a move from one institution to another (p.324).

In most real-life situations the effects of environmental discontinuity are impossible to disentangle from those of loss. In its purest form, environmental discontinuity, as a cause of negative effects is present

when anticipated loss is not associated with the move. Despite being unable to tease out the precise etiology, the move from community living to institutional residence is a major environmental discontinuity that causes severe disequilibrium for the aged person.

The previous studies offer evidence that relocation, particularly when it is involuntary, constitutes a serious threat to the elderly and frequently results in physical and/or psychological deterioration or even death. However, many variables appear to interact with the relocation per se. When the move is to a long-term care facility, some of the relevant variables are psychological functioning, physical condition, type of facility to which the relocation occurs, nature of residence prior to relocation, and anticipatory reaction.

3.4 Adjustment To Institutionalization :

How one defines adjustment, especially adjustment to an institution, is a critical problem and several writers have addressed themselves to it. Riesman (1954), in an article on clinical and cultural aspects of aging, describes three groups of aged persons (1) the autonomous, (2) the adjusted, and (3) the anomic. He sees the "autonomous" as those people who are able to maintain and often to increase their pace in old age in such a way so as to avoid the cultural change and physiological "insults" that beset older people. The "adjusted" are able to make the transition to old age successfully. If they lose their jobs, they are able to find substitute activities which gratify their needs. Their lives are sufficiently integrated so that they do not require institutionalization, psychotherapy, or welfare aid. The momentum of their early years seems to be able to carry them through this last period of life. His last group, the "anomic" are maladjusted.

and the group in need of physical, psychological and social services. Despite their age, they lack psychological maturity and the ability to plan for themselves.

Otto Polack (1948) discussed the measurement of individual adjustment. He points out that although the term adjustment is widely used by social scientists, there have been few attempts to designate objective referents which would permit the development of dependable measures of individual adjustment.

Studies by Cavan et al (1949) stressed life-long adjustment and flexibility as being conducive to good adjustment in old age. Similarly, Greenleigh (1952) believed that the way an individual handles his own aging depends to a large degree upon attitudes towards old age which were formed early in life, and he felt that the evidence favours better adaptation to the physiological changes on the part of persons who adjusted successfully to earlier life situations. Both of these approaches to the problem emphasise the difficulties involved in attempting to define the term so as to permit scientifically acceptable measurement of degrees of adjustment.

Morgan (1937) in one of the earliest studies of factors related to personal adjustment in old age, points out the importance of providing older people with a future by stating "... it is clear that the active and interested old person is the well adjusted person and that although the majority reported enjoying life, they also reported little in the way of plans, even for the morrow."

Ju Shu Pan (1950) studied the factors in personal adjustment of old people in church homes for aged. He compared the adjustment of individuals in institutions with the adjustment of persons in the general population and the relations between their activities and attitude scores and those

factors making for successful or unsuccessful adjustment. He found that institutionalized aged included more females, who were better educated, had good health care and many hobbies, were deeply religious, and felt a sense of economic security. They also had unfavourable family relationships, less contact with friends and less opportunity to participate in group activities.

W.D. Blake (1949), studying the adjustment of residents to a Home for the Aged found that three factors seemed common in the adjustment of these people :

- 1) Satisfaction with the life work of the individual seems an essential to smooth adjustment of these people.
- 2) Congenial companionship of contemporaries seems to facilitate a pleasant adjustment.
- 3) Having a few interests or hobbies outside the job and concentrating on them is a factor.

Taietz (1953) found that there was a direct relationship between the policies existing in an institution and the personal adjustment of residents in homes for the aged. He reports that when residents were questioned about policies and practices, they tended ...

... to express their approval or criticism of the home by evaluating the superintendent and other staff members. In each of these homes there had been a change of superintendent within the memory of most of the residents: dissatisfaction with the incumbents was often expressed by extolling the virtues of the predecessor or by direct comparison of the two. The comments that the respondents added to the question reveal two dominant themes; the first pertaining to the vital role of the superintendent in the adjustment of the residents in a home for the aged.

Typical comments were that "the superintendent makes the home" and they confirm statements in the literature regarding the crucial role of the superintendent. The second theme suggests the qualifications that the residents looked for in the superintendent: predominant are sympathy, understanding, fairness, a closeness to an identification with the residents (p.20).

Oberleder (1957) studied the behaviour of institutionalized aged persons in relation to their attitudes towards old age. From the postulate that aged individuals are more likely to become frustrated and maladjusted in instances where earlier life goals are retained and conformity to the cultural patterns for the aged is resisted, it was hypothesized that a group designated as "Management Problems" as compared to a group designated as "Institutionally Adjusted" is characterized by: (1) more expressed denial of the stereotypes of the aged; (2) more expressed retention of the goals and values of earlier maturity; (3) more expressed disturbances over changes associated with the aging process. Results indicated the strong possibility that the Institutionally Adjusted had accepted old age despite their espousal of the younger viewpoint, whereas the Management Problem group had not accepted their age, although they expressed the older viewpoint on the questionnaire.

Stotsky (1967) conducted a study to determine the parameters of adjustment in a population of psychiatric patients who were relocated to nursing homes. The variables included nursing home characteristics, staff training and attitudes toward the mentally ill, the patient's history, the patient's mental and physical status and case worker intervention.

Subjects were elderly psychiatric patients transferred from a state mental hospital to nursing homes. The placement was termed successful

if the individual was not returned to the mental hospital within six months. Unsuccessful adjustment was defined as a return to a psychiatric ward or death within six months after the transfer. The study found that 80% of the patients were successfully adjusted, 9% returned to the hospital and 11% died within the first six months in the home. The mortality rate in the study is lower than that reported by Aldrich & Mendkoff.

The results indicated that the patient's mental status was the primary factor influencing adjustment. Those patients who were unsuccessfully adjusted manifested significantly more psychiatric symptoms following relocation than the successfully adjusted patients. The only other significant variable was the attitude of nurses in the homes. Nurses in homes where the majority of the subjects were successfully adjusted, were significantly less authoritarian, more benevolent and less socially restrictive. Nursing home characteristics and casework activity were not significantly related to adjustment.

Dick & Friedsam (1964) studied both personal and social adjustment in residents of homes for the aged. They distinguished between the generic and the operational concepts of adjustment: adjustment turns out to be basically a common sense term, a generic one which may subsume such concepts as 'morale', 'happiness', 'life satisfaction', 'well-being', and 'successful aging'. In an operational sense there appears to be two major aspects or dimensions of adjustment - an objective aspect, where emphasis is placed upon a persons' activities and social participation, and a subjective one, having to do with a person's internal frames of reference and attitudes toward life.

Bennett & Nahemow (1965) suggest ...

Residents of homes are expected to participate in activities,

develop informal relationships, obey rules and do very little complaining. Social integration as indicated by participation in formal and informal activities, is generally the major criterion of adjustment (p.50).

In an earlier paper, Bennett (1963) claims that once institutionalization has taken place, members of staff gear themselves primarily to the task of facilitating the adjustment of residents. A social worker within a specified home was asked to list the criteria of well adjusted residents. They were: 1) one who isn't too afraid of authority; 2) one who maintains outside contacts; 3) one who participates in activities in the Home; 4) one who can face the frustration of regulations, e.g. by obeying the doctor and taking his medicine, and 5) one who accepts a roommate even if he has grounds for complaints.

According to one administrator,

Residents are expected to behave as ladies or gentlemen. They are expected to be courteous and say 'hallo' to all including staff members. They should be clean and dress nicely... The well adjusted individual is part of the group. He is neat in appearance, because the others will be critical of sloppy people. He participates in activities of the Home and helps those who need help (ibid, p.121).

The good resident is rewarded by becoming a staff favourite and by being asked to help with various jobs. A bad resident will be spoken to by social workers, administrators and often by psychiatrists.

Turner et al (1972) focussed their efforts on personality traits as potential predictors of institutional adaptation among the aged.

The assumption behind this approach is that, "those aged with pre-

institutional personality traits that are congruent with the specific demands of the relocation environment will experience a minimum of stress". Such congruent personality traits are felt to facilitate adaptation, because the impact of relocation will be reduced when there is a relationship between traits and specific adaptative demands of the environment.

Data was obtained from eighty five elderly persons, prior to, and one year after moving from the community into homes for the aged in Chicago. The results indicate that for the person undergoing the stress of institutional adaptation, congruent traits facilitate positive adaptation. In addition, the particular trait found to be associated with successful institutional adaptation loaded strongly on activity, aggression, and narcissistic body image. This organization of traits suggests that a vigorous and perhaps combative style of behaviour is functional for institutional adaptation.

Slover (1972) measured the environmental qualities of 26 settings to which a group of elderly mental patients were transferred. The settings were rated by an environmental anthropologist on 189 physical, social and service related qualities on the basis of a day's observational visit to each. Decline following relocation i.e. poor adjustment, was greatest in those who had been placed in environments lacking warmth, individuation, and autonomy.

Curry and Ratliff (1973) investigated the association between nursing home size and two variables, namely, isolation and life satisfaction. Specifically, they postulate the environment of small institutional structures to be more conducive to the formation of primary relationships, indicating satisfactory adjustment. This potential, coupled with the confines of limited space, suggest less opportunities for social and/or

personal isolation. By the same token, as satisfaction is often related to the intimacy and frequency of such primary associations, the author expected satisfaction to be higher in smaller, as opposed to larger institutional contexts.

The findings indicate that social and personal isolation does increase with the size of the institution. On the other hand, life satisfaction scores were essentially the same, regardless of the size of the home in which persons were living.

Kahana (1975) operationalized 18 aspects of the milieu, as measured by staff consensus, as well as the residents' view of their personal needs along each dimension. Her hypothesis was that congruence between resident needs and environmental opportunities to exercise the need would be associated with high morale. The hypothesis was upheld in two of the three long-term care institutions. Especially important areas of person-environment congruence, were privacy, impulse control, stimulation, continuity with the past, and change versus sameness.

Schwartz and Proppe (1969) in an early investigation of the institutionalized aged, found that the desire for privacy among them correlated highly with length of time in the institutional setting and not at all with such demographic variables as education or marital status. They later (1970) postulated that person/environment transactional variables are significantly related to levels of positive self-regard in the elderly. Schooler (1969) addressed himself to the ever recurring question: does environment make a difference to the elderly and if so, in what way? A parallel theme is echoed by Lawton (1970, 1974) who describes a framework for suitable integration of the older person and his environment. Lawton's scheme of behavioural indices, ranging from simple to complex, offers an approach to matching the person to the

appropriate environment, thus opening a broader range of alternatives for residence selection. Schwartz (1975) draws the researcher's attention to how crucial the environment is in facilitating the adjustment of prospective aged residents to homes ...

All of which is to point out that those who study aging are gradually coming to understand that the environment is not simply the backdrop, the "scenery" against which the lives of older persons are lived. If, indeed, such were the case, then planning the micro-environment for older persons could be construed (as it often used to be) as merely repainting or rearranging the environmental scenery, in effect, an architectural exercise. We are rapidly discovering that quite the opposite is true.
(p.281)

Bayne (1970) suggests that in large measure the dependency, apathy and withdrawal, so frequently observed in elderly residents may be a function of their accommodation to an environment that purports to promote health, but actually encourages the sick role, that provides treatment, but does so through regulation and control. The very effectiveness of such a program can literally endanger the patient's will to self-determination.

In one of the most recent studies on adjustment to a Long-Term Care Institution, Rodstein et al (1976) reported on 100 elderly persons consecutively admitted to the Jewish Home and Hospital for Aged and studied during the first month after admission. Medical changes (chiefly cardiovascular) and behavioural changes were analysed independently and then correlated. Four sub-groups were found 1) smooth adjustment with no significant medical changes (33 subjects); 2) smooth adjust-

ment with significant medical changes (17 subjects). 3) severe adjustment problems but no significant medical changes (31 subjects) and 4) severe adjustment problems with significant medical changes (19 subjects). The aged persons most likely to have initial adjustment difficulties usually had poor capacity for interpersonal relationships, were socially isolated, were either single or divorced, had a dependent personality, had severe chronic brain syndrome, had a negative or ambivalent attitude toward admission, and often had been referred for psychiatric evaluation before admission. Major patterns of reaction were anxiety, aggressiveness and depression. Significant medical changes were more likely to develop in those with previous poor health who manifested an advanced state of confusion and depressive trends. Depression was related to concomitant medical changes rather than to the previous health status; it exacerbated the reaction to medical illness, which resulted in a decline in the level of functioning.

From the review of the literature, it is apparent that there is no consensus as to what adjustment is. It means different things to different people. Factors such as voluntary versus involuntary placement, presence or absence of preparation, degree of environmental change generated by the relocation, physical and mental health, personality variables, and type of facility, all appear to affect adjustment. Although some information has been obtained on the effects of these variables, the role of each has not been well determined. This is partially due to the differences in variables and technique in the studies investigating this area. The research studies cited in this section have varied in terms of the population studied, type of long-term care facility, psychological and physical parameters investigated, measurement techniques and the criteria for adjustment.

3.5 Therapeutic Strategies Available In The Rehabilitation Of Institutionalized Patients :

From Goldfarb's (1953, 1955, 1957) lengthy experience in treating institutionalized patients, he believes that many of these patients appear to be outwardly depressed but are more self-aggrandizing than self-depreciating. Although feelings of failure and frustration are expressed, the environment is usually blamed and attacked, frequently in a paranoid fashion. These patients reveal little evidence of guilt, but fear of retaliation is usually present. They do not seriously contemplate or attempt suicide, although they make such gestures. Although they often express a wish to die, to "go soon", or "have it over with", they protest lack of courage or give moral and social reasons for their self restraint from suicide. Outstanding is the complaint of joylessness, lack of pleasure, feelings of futility and hopelessness. For them, eating, sleeping, personal relations, work, hobbies and entertainments are not pleausurably anticipated, presently enjoyed or happily reviewed. (Wolff , 1970)

Barton (1959) described the above symptoms as being a part of the "institutional neurosis". The inmate becomes over-dependent, does what he is told, loses initiative and interest and becomes one of a group of automatons. The joylessness with the sense of futility and hopelessness is a means of obtaining and guaranteeing care. Old folks want pity, compassion and care from parental surrogates and frequently do not permit themselves pleasure. They often prefer to feel persecuted and deprived. Seligman (1974) has pointed out the similarity between the conditions imposed upon the resident of an old age facility and what he calls "conditioned helplessness". His research

has indicated that organisms which lose all control over their environment may experience complete helplessness and premature death.

"So if a person or animal is in a marginal physical state, weakened by malnutrition or heart disease, helplessness can push the scales towards death. One of the most vulnerable groups to death by helplessness is the aged. In America, growing old is tantamount to losing control. Forced to retire at 65, sent to an old-age home, ignored by relatives, the old person is systematically stripped of control over his life. We kill many of our senior citizens by denying them choices, purpose in life, control over their lives. Many of these deaths are premature and unnecessary." (Seligman, 1974, p.84).

Gerontological theoreticians and research workers have described the effects of institutionalization fairly systematically, but what alternatives do they pose in the amelioration of these deleterious effects? Gottesman, Quarterman, and Cohn (1973) have conceptualised four levels of treatment: (a) self treatment, which focuses on the life style of the individual in adjusting to the changes in self and the environment; (b) individual psychological treatments; (c) small group therapy, and (d) societal treatment. In the following section we shall consider the various ameliorative procedures that have been employed to aid in the adjustment of the institutionalized aged.

(a) Individual Psychological Approaches: It is well known that Freud (1924) did not favour individual psychotherapy for patients over 45 years of age. He believed that after that age the patient's character would not be flexible enough to make the necessary personality changes demanded of him once he had gained insight into his condition. Memory

disturbances were also believed to represent an obstacle to treatment, because the elderly patient might not be able to recall details of his childhood which would be important for the analysis. Fenichel (1945) preferred not to treat geriatric patients with individual psychotherapy and he became, to a certain degree, responsible for the pessimistic attitude taken by psychoanalysts.

Abraham (1949) introduced the first note of optimism regarding the analysis of the aged. He described the successful analysis of several patients about fifty years of age and concluded that ... "the age of the neurosis is more important than the age of the patient" (in Rechtstaffen, 1959). Jelliffe (1925) also published satisfactory results with psychoanalytic treatment of elderly patients and concluded that chronological, physiological and psychological age do not go hand in hand. Alexander (1946) in (Rechtschaffen, 1959) modified the psychoanalytic technique emphasizing two different forms of individual psychotherapy, insight therapy and supportive therapy. He claimed that the primary consideration in the treatment of the aged should be the degree of ego strength available. But where for a variety of reasons the ego is weak, then it is unreasonable to encourage release of impulses, since the ego will not be able to control them. In cases where the patient's need for assistance is answered by actual guidance, where anxiety is relieved by the therapist's assuming a protective role, where inferiority feelings are met with reassurance, and where guilt is relieved by permissive attitudes, supportive therapy is indicated.

Grotjahn (1940) has reported successfully treating emotionally disturbed geriatric patients with individual psychotherapy. He thinks that resistance against unpleasant insight is lessened in old age and that even "narcissistic threats" for the Ego become acceptable. He believes

that the neuroses of old age are defences against castration anxiety. Old infantile wishes do not die, nor do they fade away; they are waiting to return. The elderly subject must go through a reverse Oedipus Situation where not the son fears the father but the aging father the son. He must work through his unconscious relation to the son.

Kaufmann (1940) discussing the analytic treatment of depressions in old age, describes the inverted Oedipus complexes occurring in such instances. Aged and dependent individuals may regard adult offspring much as they formerly regarded their own parents. Considerable ambivalence takes place when the patient, who once helped his child in growing up and was the authority figure, now has to take orders from his children.

Merloo (1955) by analytically oriented psychotherapy, was able to help elderly patients rediscover hidden inner resources and thus conquer their feelings of uselessness and boredom. Weinberg (1956) modifies traditional and analytic techniques and uses a more active and less formalistic approach to individual psychotherapy with the aged. He maintains that the therapist has to enter more freely into a relationship with the patient and also to manipulate, if necessary, the environment in which the older person lives. This may range from educating family, friends and those who are entrusted with the care of the aged concerning their needs and the detection of symptoms, to a dogged gnawing at the conscience of society to provide the necessities for a better emotional climate for our aging population.

Goldfarb (1953) has used a very different technique of individual psychotherapy with geriatric patients and has reported good results. His approach is based largely on psychoanalytic thinking. Working in a home for the aged, Goldfarb and his associates have devoted themselves to the development of practicable, individual psychotherapy for their

clients. His patients were treated with brief and widely spaced sessions. The maximum length of each session was fifteen minutes. The aim in each session was to provide emotional gratification for the patient and to increase his self esteem. This approach has deliberately attempted to use the increased dependency of the aged as a therapeutic resource. Reasoning that the increased dependency makes the older person prone to view the therapist as a parent-figure (just the opposite of the reverse transference noted by the psychoanalysts), Goldfarb attempts to encourage this misconception to the extent that the patient develops the illusion that he is actually dealing with a very powerful parental authority who is capable of wielding great influence in his life. Once this illusion is firmly established, it is then used to provide gratification of emotional needs for affection, respect and protection. In this way the patients win over the potentially threatening authority figure as an ally. When he verbalizes his resentment against the therapist but is able to win the therapist's protection all the same by "defeating him", the geriatric patient feels more powerful and gains in strength.

Wolff (1970) claims:

Since 1954 I have been able to treat a number of geriatric patients of both sexes in psychiatric institutions, using "Brief Therapy" as recommended by Goldfarb on psychiatric wards, and have found it effective and useful with elderly patients suffering from acute and chronic brain syndromes associated with cerebral arteriosclerosis, with senility, chronic alcoholism, central nervous system syphilis and with geriatric patients suffering from neurological disorders of various kinds. This technique definitely helped these patients to gain Ego-strength by increasing their self-esteem, by verbalizing their resentment and anger. Most notably helped were

patients who were management problems on the ward by being upset, excited, threatening to other patients and to personnel; patients with poor toilet and eating habits; and others suffering from depressive features and refusing to eat. This form of treatment also brought a few delusional patients nearer reality. It was also of use in encouraging listless and apathetic patients to participate with greater interest in recreational and occupational activities and to further their socialization and rehabilitation program (p.113).

Oberleder (1970) reported the application of "crisis therapy" to twelve patients over 60 years of age who had been admitted to a state mental hospital with the diagnoses of senile psychosis or arteriosclerosis with psychosis. The treatment consisted of brief psychotherapy involving family and other significant persons. The therapy is applied at a time when the individual may be maximally influenced - when he is in a crisis. Hospitalization without strict treatment goals at such a time may have the effect of exacerbating disorganization and regression. Crisis therapy, on the other hand, is aimed at "catching the individual off guard" and turning reduced resistance to good effect by encouraging free expression of feelings, and unblocking repressed material. In such a manner, all twelve patients recovered to a degree sufficient to allow discharge from hospital. It is significant that Oberleder describes such an approach as being specifically geared to persons for whom long-term psychotherapy is not suitable, especially the aged and those from low socio-economic groups. Unfortunately, the evidence suggests that this sort of therapy tends not to be available to the majority of the elderly.

Buttler (1977) suggests that because of the tendency of older people to review their lives, to seek meaning, to deal with death, there is an

obvious existential component to any therapeutic work with them. Yet existential therapists have not demonstrated great interest. He points out that the ideas of Buber and Frankl are particularly useful for older people.

Gottesman, Quarterman, and Cohn (1973) have summarised developments in behavioural modification therapy and, citing the review of Gendlin and Rychlak (1970), Krasner (1971), and Ullman and Krasner (1969) have identified four major techniques used with aged patients: positive reinforcement, desensitization, aversive procedures, and modelling.

Thus, to all intents and purposes, it is apparent that individual psychotherapy and counselling for the aged, which was once frowned upon, is now practiced in many forms. What is lacking however, is an attempt to carry out meaningful research into the efficacy of the various individual treatment approaches. Then, and only then, will we be in a position to evaluate which approach is the most therapeutic.

(b) Group Approaches: This had been attempted primarily in institutional settings by several therapists. There are several immediate advantages to group therapy of aged patients. First, such therapy allows the usually scant treatment personnel in such institutions to reach a significantly larger number of patients than with individual psychotherapy. Second, the interaction with other group members may be at least as therapeutic as the interaction with the group leader.

Group therapy in institutions usually focuses on simple matters of resocialization, adjustment, etc., rather than a restructuring of the personality or basic conflict patterns. The goals of group therapeutic techniques in homes for the aged have been isolated by Feil (1967) into two primary categories; first, to stimulate verbalization and interaction among group members and second, to promote a sense of self-worth so that

the individual can move toward some degree of independent action which will make him feel part of the community life of the home. (in Eisdorfer and Stotsky, 1977).

Burnside (1970, 1971, 1973) has indicated that loss was a persistent theme emerging from group work with the aged in nursing homes. Topics for discussion centred upon deceased loved ones, disabilities, and loss of independence. It is believed that group work helps by allowing the patient to discuss and share losses. The key parameters of therapy were reported to be warmth, patience, the ability to listen, perseverance and flexibility.

It is not the author's intention to cover these approaches in great depth; suffice to say that although it has been shown that group therapy and remotivational programs on geriatric wards are obviously worthwhile, they must be continued in order for improvements to be maintained.

According to Eisdorfer & Stotsky (1977):

... group techniques combining verbal and non-verbal modalities have achieved wide acceptance, but there is still a lack of carefully controlled studies to determine the efficacy of various approaches. It is hard to sort out the more from the less successful programs and to determine the importance of therapist skill and type and mix of patients in achieving successful group experiences. Patient selection factors, the enthusiasm of the therapist, anxiety reduction in the staff because someone is "treating" the patient, and the confusion between process and outcome (particularly when no outcome measure is employed at the start) do little to clarify this picture, and only emphasize the problems of separating any main effect of treatment from the placebo effect.

(c) Institutional Rehabilitation: In many institutions it is common to find the elderly patient sitting with hopelessness and depression on his/her face, uninterested in his/her surroundings, listless, apathetic, and at times there is a neglect in personal appearance. These patients convey the feeling of being outcasts of a society which does not care if they live or die, believing at times that "they would be better off dead" because "nothing can be done for them". They are just old people waiting to die.

Behind every attempt to rehabilitate an aged resident is a theory of what constitutes successful aging. The two major theories that have contributed to our understanding of this phenomenon (if there is one) are Disengagement and Active Involvement. Both have useful contributions to make, but as Wolff (1970) says ...

There is no simple theory of successful aging which can account for all the people in their later years. There is some disengaging force to withdraw from society in some persons over 70 or 80. But most of them will retain the attitude toward life of their middle years. Those who were happy and satisfied in their activity and productivity will then continue to be happy and satisfied if they can maintain a considerable part of their activity and productivity. Those who were happy and satisfied by being relatively passive and dependent in their middle years, will be happy and satisfied if they can become even more disengaged in their later years (p.190).

Therefore we can see that the problem of rehabilitation is not a simple one. Cosin (1953) has classified geriatric rehabilitation into three categories: (1) ideopathic rehabilitation - the restoration of

function following a disability that results from a major pathological process (fractured femur, hemiplegia or rheumatoid arthritis); (2) heteropathic rehabilitation - a general restoration of activity despite a pathological process affecting the efficiency of the body as a whole; and (3) combined heteropathic and ideopathic rehabilitation.

Rusk and Dasco (1956) classified the rehabilitation of old people into three groups: (1) restoration of the obviously handicapped patient; (2) restoration of the chronically ill person who has no signs of manifest disability; and (3) restoration of the elderly person who is not obviously ill but whose physical fitness is impaired. In this section we shall briefly consider the various milieu approaches used to rehabilitate geriatric patients.

(a) Occupational Therapy with the Geriatric Patient: The importance of an active occupational therapy program for the chronically ill and the aged has been described by Knudson (1954), Ferderber (1956), Blustein (1960) and others. Blustein recommends a special occupational therapy program for elderly veterans using many varieties of handiwork with simple tools and devices. These include leather work, woodworking, basketry, weaving, painting, knotting, hooking rugs, knitting and copper tooling. Library clubs were started by librarians for the purpose of giving book reviews and discussing current events. Hobbies were encouraged, such as keeping scrapbooks, making joke books, cutting out cartoons and pasting them into books. An aquarium was maintained in the ward, and interest in nature study encouraged.

Pearman and Neuman (1968) have described an excellent work oriented occupational therapy program. This approach is particularly designed to reach older patients who are withdrawn. They performed contract work consisting of counting, packaging and boxing small toy items

for shipment. Volunteer work for community agencies such as counting and folding printed materials, stuffing envelopes and preparing them for mailing, was done. Group outings financed by their earnings promoted socialization and a sense of identity with the group and the community.

Occupational therapy for geriatric patients in mental institutions and clinics has been prescribed for many years, but usually only for its physical or orthopaedic benefits. Today, occupational therapy is employed more for its benefit in alleviating psychological and sociological problems. Fidler and Fidler (1954) believe that occupational therapy is "a set form of psychiatric treatment which uses constructive activity as a *modus operandi*". Menniger (1942), on the other hand, recommends hobbies and recreational and occupational therapy to release tension, to compensate for real or fancied inadequacies, to decrease feelings of inferiority and to give outlets for restlessness and hostility.

(b) Recreational Activities: There is some difficulty in understanding precisely what this term means. According to Gumpert (1953), it means the restoration of, or the growth of, functions which have been abused or neglected in the routine of living. He believes for man to keep, maintain, and restore the normal rhythm of life, we are in need of recreation. For elderly persons, recreational activities are necessary and of value when they create an atmosphere of release from tension, or relaxation and when they "charge" them with new energy. Recreation can give a new direction to an older person's life and help him to find and to develop possibilities of emotional growth and intellectual understanding which the elderly individual has not dreamed of.

"Creative insight", Hutchinson (1941) pointed out, never occurred during the peak of mental effort but always during a period of relaxation. Relaxation, decrease of tension, and leisure are needed and achieved by recreational techniques which help us to return to a new, more creative life. The recreational techniques to be used, with the purpose of relaxing the elderly patient, have to be chosen with great care and understanding of the elderly individual's assets, previous interests and limitations. According to Menninger (1942), the elderly person with a hobby is almost always an alert, interesting person. Recreation is an extremely important aid to growing older gracefully. People who remain young despite their years, do so because of an active interest that provides satisfaction through participation.

(c) Music Therapy: Boxberger and Cotter (1968) found that participation in music activities had a beneficial effect on the behaviour of geriatric patients who lived in a hospital environment for many years. There was an increase in appropriate behaviour, reduced aggression, less physical and verbal reaction to hallucinations, reduction of frequency in incontinency, improvement in personal appearance, and a lowering of the level of undesirable patient noise. Music activities, according to the authors, assist in developing a more creative life, cultivating new interests, engaging in new activities, and re-establishing the necessary bonds with society.

(d) Physical Therapy and Hydrotherapy: According to Blustein (1960) electrical stimulation combined with Buerger-Allen exercises for circulatory disturbances in the lower extremities, general conditioning exercises using the stationary bicycle, individual exercises - especially posture exercises to prevent complications of inactivity - were used

with success. Wolff (1970) has found that cold baths, scotch douches and active exercises, friction with cold water and general massage were frequently effective against symptoms of general weakness, fatigue, and tiredness for elderly patients.

From the above data it appears that physical therapy and hydrotherapy have also been found to be of value for geriatric patients.

(e) Psychiatric Approaches: Knudson (1956) has indicated that psychiatrists should play an "aggressive" role in promoting rehabilitation for the purposes of increasing work capacity, physical tolerance, mental alertness and emotional stability. Braceland (1957) is of the opinion that psychiatry and rehabilitation deal with two of the greatest adversities that befall mankind: mental and physical disaster, whether innate or acquired, acute or chronic, temporary or prolonged. Both processes deal with an individual who lives, feels, thinks, struggles and expends his energy against a threat to his integrity. Both disciplines therefore have to rehabilitate man "as man", no matter how badly he may be or how seriously restricted his activities are. The objective is to return the patient to society a "complete person" who is adept at the skills of living and, if need be, with a revision of his/her body image, self concept and ability to relate to others. For this purpose, the psychiatrist will have to work with the mature aspects of the patient's personality in order to prevent chronic regression and lasting disability.

Timm (1965) emphasises that an effective psychiatric program for geriatric patients will ensure no correctable physical defect is overlooked or untreated, anxiety levels will be reduced, psychiatric therapies to meet specific needs will be applied as in any age group, and an activity program will be designed around the individual patient

to restore his/her interest in others and to give meaning to his/her life.

Rehabilitation as part of a larger program of intervention was very successful and well received in nursing homes (Stotsky, 1967). In each instance, it was imperative to adjust the program to the facility and to develop programs which could be continued after the intervention team left. Staying attuned to the patient's routine daily concerns and immediate needs was a key factor. (Eisdorfer & Stotsky, 1977)

Hefferin (1968) reviewed rehabilitation in nursing homes and found success to be related to the patient's mental and physical status, social situation, the experience, training, and rehabilitative orientation of personnel, the availability of rehabilitative resources in the community and the home's ability to afford the cost of the program.

Foreyt and Felton (1970) suggest that rehabilitation programs with older patients have changed staff attitudes from physical care to inter-personal interaction, which has improved the patient's daily behaviour. According to these authors, this change in orientation has 'sparked off' a totally new approach to the residents of institutions and the remnants of custodial care seems to be fading quickly. Wolff (1970) stipulates that the primary importance of conveying hope, re-establishing confidence, and overcoming undue fear of death, are necessary ingredients of any rehabilitation program. The term "milieu therapy" was introduced to describe the techniques for remotivation, resocialization, and reorientation of patients through involving the entire staff (and patients themselves) as therapeutic personnel. (Gottesman, 1973)

Eisdorfer & Stotsky (1977) believe ...

a recurrent theme in the literature is the need for total

mobilization of resources (Remmerswaal, 1972) including an activity program (Davis, 1967; Herman, 1968), occupational and/or recreational (Stour, Finnegan, and Delcioppo, 1966), physical (Morison, 1969), and other forms of therapy to stimulate patients to respond. (Loew & Silverstone, 1971) Saul, Turner, and Goldfarb (1967) stress the importance of social interaction among staff and residents. In the Soviet Union, restorative therapy is felt to affect markedly the social and biological adaptation of chronic patients. (Kabanov, 1967) p.739.

In the final analysis, the goal and purpose of the rehabilitation program for the geriatric patient is, therefore, to restore and keep the patient's physical strength and vigour and to help him/her regain his/her emotional equilibrium. The mental health professional's role must be geared towards helping the aged realize that they can compensate for their decline in physical attractiveness by giving greater value to the intellectual and emotional factors of their life's experiences, and by developing patience and wisdom. The practitioner must help them not to consider decrease in sexual potency and physical strength as completely negative, but instead to sublimate these energies by redirecting their free floating libido to contemplation, cultural achievement, or religious activities. No real rehabilitation can, however, take place unless the fear to die, present on a conscious or unconscious level in nearly all persons, can be overcome.

In summary, we see that various treatment approaches have been used to facilitate adjustment in geriatric patients. Individual, group and milieu approaches have all been used with varied success, each concentrating on specific aspects of rehabilitation, namely, physical, psychiatric, social, occupational and recreational. A review of the literature

however, reveals that many of these treatment programs are employed on an 'ad hoc' basis and more research is therefore indicated to ascertain which approaches have the greatest benefit for the aged citizen.

CHAPTER 4

‘A sea of people everywhere.
The waves keep breaking
and lifting without end.
But who can put to rest
ones thirst and hunger
for a dear, a trusty hand?’
I.E.Ronch.



Rationale and General Aims of Study.

A thorough review of the literature has indicated that there are numerous modes of viewing institutionalization of the aged. It is the author's opinion that previous research findings can be grouped into three broad categories. These are :

- (a) studies that have examined the effects of institutionalization,
- (b) studies that have looked at the crucial components of what constitutes adequate adjustment, and
- (c) Studies that have attempted to discover methods to alleviate or minimise the problems posed by the process of institutionalization.

In the last thirty years, both the quantity and quality of gerontological research with respect to institutionalization of the aged population,

has increased and improved our knowledge of the crucial parameters involved in this process. At this point, however, we are still unable to draw upon a theory which is capable of providing us with a means of charting the stages that the prospective newcomer (to a residential setting) passes through on his/her path to becoming well adjusted. Furthermore, we have little indication as to how long the adjustment takes, and when in fact it is complete.

Lieberman and Tobin (1976) have made a substantial contribution to facilitating our understanding of the sequence of events that the aged newcomer might pass through along the road to adjustment. However, they have failed to outline in sufficient detail ways of coping and dealing with problems which may arise in the adjustment process. Likewise many other theorists (for example, Stotsky, 1967; Foreyt and Felton, 1970; Locker and Rubin, 1974; and Brody, Kleban and Moss, 1974) have attempted to assess the effects of moves on the overall adjustment of aged residents at different points in time but they have seldom incorporated a treatment program to minimise the most significant effects of such a process. Those geriatricians who have developed programs to treat the problems of the new residents, have done so on an ad hoc basis, without attempting to integrate their rationale for treatment in a theoretical superstructure. It is therefore apparent that what in fact is lacking is the application of theoretical knowledge in the development of specific treatment programs.

There are strong indications in the literature that the decision to, and the process of becoming institutionalized poses a major crisis for the aged newcomer. Although many adverse changes will have occurred in the aged person's life during the last few years prior thereto, the move to an institution is seen as the most catastrophic. From her study of rural elderly,

Twente (1970) reported ...

Of all the moves to other housing, the one most dreaded is that to an institution. The older person who needs institutional care often resists leaving his home in order to postpone the time when he is admitted to a place within four walls. Sometimes it seems he hopes to be able to live with a son or daughter instead. Aging men and women may refer to the time when they themselves took care of their own parents. They dread the prospect of institutional care because some see it as the end of what little independence they have. Certainly what remains of freedom is likely to vanish once a person is inside institutional walls (pp.61-62).

Meacher (1972) claims that many residents arrive at an old peoples home having been taken for a ride by car or train and find themselves dumped, without explanation, in a home they have never seen. This produces bewilderment, confusion and an inability to cope with admission, with the result that the mortality rate is high.

Lieberman & Tobin (1976) hold that, after entering an institution, there is an immediate reaction ...

The severe stress of institutionalization occurs in its most extreme form just after entering the home, when the old person first has to sleep in a bed foreign to him, adjust to the idiosyncracies of a roommate, live in a congregate environment, and learn the positive and negative sanctions of a new social world The manifestation of the first month syndrome for some residents takes the form of almost total disorientation in time and place; for others, affective disturbances such as deep depression, and for others, rather bizarre behavioural symptoms. The first month is

a period of continual ups and downs for some residents, whereas for others there is immediate disorganization followed by an upswing and then a stabilization at a level of functioning that is somewhat worse than their preadmission level (p.123).

Milloy (1970), in describing the meaning of institutional life has stated,

... he may miss the noise, the sight and the smells of a familiar neighbourhood or the disorder and long-established routines in his home, through which he may have defended himself against anxiety and encroaching mental confusion. He may be deprived of his favourite foods, which he formerly ate when he pleased. He may fear surrendering his individuality and integrity. Being in the midst of so many disabled people and being cared for by strange nurses and aides, he may feel he will never again be anchored by the security of a comforting relationship. The impact of so many new stimuli can demoralize and numb him to a point at which his motivation to live is weakened ... Pain and loss beyond his control constitute an assault on his ego that may trigger a response of panic or apathy (p.452).

From these quotations we can see that the losses associated with becoming a resident are vast, and compound with the premorbid personality to produce the lowering of self-esteem, a decrease in levels of daily activities and the inability to relate to others. Once the older person actually enters the home he/she enters a period of acute disequilibrium lasting one or two months and then an adjustment is made. The internal changes that accompany this major move are decrements in cognitive functioning as manifested by disorientation in respect of time, place

and person, an increase in depression and anxiety, more body preoccupation and a perception of self as possessing less capacity for self-care and as more hostile in interaction with others. Essentially the new resident has become one patient among many old, sick, and frail elderly. In identifying these people, the resident develops increasing pre-occupation with body functioning, and incapacity sets in.

Therefore to all intents and purposes, final placement in an institution precipitates what contemporary theorists term a crisis. Caplan (1961) defines a crisis as ...

A state provoked when a person faces an obstacle to important life goals that is for a time insurmountable through the utilization of customary methods of problem-solving. A period of disorganization ensues, a period of upset, during which many abortive attempts at solution are made. Eventually some kind of adaptation is achieved which may or may not be in the best interests of that person and his fellows (p.18).

The crisis situation is equal to a relatively short period of psychosocial disequilibrium in a person who confronts a hazardous situation that for him constitutes an important problem which he can for the time being neither escape nor solve with his customary problem solving resources. The crisis state is also characterized by feelings of anxiety, depression, helplessness and hopelessness.

The literature makes it clear that there are a number of stages in the crisis state, (Caplan, 1964; Hirschowitz, 1973) many of which overlap and are not clear cut. Three crucial stages have been delineated, namely:

(a) Impact: During this stage the individual experiences feelings of bewilderment and confusion as his defences fail him. He may try to

wish the event away or to pretend it has not happened.

(b) Recoil: As the individual exhibits increased evidence of disorganization, he reaches this stage. Uncomfortable emotions are highlighted - anger, guilt, hostility, depression, doubt. The person withdraws from the concern of everyday life and is surrounded by physical and psychological symptoms, e.g. agitation, fatigue, insomnia.

(c) Adjustment and Adaptation: This is the stage where the problem is reduced or even removed. Things which cannot be changed are accepted as inevitable. If the crisis is not accepted, pathological long term symptoms set in, for example, apathy, helplessness, etc.

"To every action there is an opposite and equal reaction."

This Newtonian law of dynamics exemplifies the effects that an aged resident undergoes when attempting to negotiate the crisis posed by the impact of institutionalization. The literature demonstrates that during this process, a great number of newcomers demonstrate maladaptive coping mechanisms, such as denial, withdrawal, retreat and avoidance. Fantasy may overlay, replace or merge with reality. Impulsive behaviour is common, rage often ventilated, and dependency needs seem to move strongly into the foreground. These reactions are in keeping with those experienced during a crisis. Caplan (1964) believes that maladaptive coping has the following characteristics :

- (1) Avoidance or denial of problems with judgements based on wish-fulfillment or fantasy rather than reality.
- (2) Avoidance and denial of negative feelings, dealing with them by projection or blaming when they do break through.
- (3) When denial and avoidance break down massive and generalized disorganization of functioning involve most areas of living.
- (4) Inability to pace oneself, either overactivity or underactivity.

- (5) Inability to seek or accept help from others.
- (6) Reacting globally or stereotypically to problems; feeling easily overwhelmed.

Crisis has been seen and studied as, (a) the change in an individual undergoing transition, (b) the cumulative toll of life change events, and (c) the signal of strain in a social system. Common to all three alternatives is the concept of stress. A stress situation exists when something in the environment causes a threat to life; a risk of injury; an actual or potential loss of security; self-esteem, or important sources of satisfaction.

Life is never without stresses. The healthy person has a variety of conscious techniques and unconscious mechanisms for coping with them. However, when an individual fails to employ appropriate mechanisms to deal with the external situations, Transient Situational Disturbances occur. This is a concept posed by psychiatry to explain overwhelming stress. The subcategories of transient emotional disturbances are now called adjustment reactions, a term that implies that quite ordinary life events may be implicated. The classification of Adjustment Reaction of Later Life is used for situational disturbances occurring as a result of stresses specifically related to aging. These include (1) physical and environmental changes, (2) retirement, and (3) loss of family members and friends. Using this model one may hypothesize that an adjustment reaction of later life is evoked by the transient situational disturbance of institutionalization.

At any point in the sequence following the initial impact of stress, the individual's normal coping mechanisms may be rendered unsuccessful. The conscious search for support and substitute gratification, together with the unconscious defences, fail to minimise discomfort enough, and

the person in question begins to show the signs and symptoms of an adjustment reaction. These may vary in number and severity but often include :

- (1) Anxiety and its derivatives.
- (2) Psychophysiological disturbances.
- (3) Behavioural disturbances.
- (4) Inefficiency and poor morale.

Prolonged symptoms accompanying a long period of stress do not abate as promptly after the stress is removed as do those of short duration. Anxiety and related symptoms sometimes persist for weeks or months after the problem that produced them is resolved. Maladaptive behaviour patterns can become habitual and remain as permanent residuals. Thus if a stress situation fails to be resolved, a patient/resident may, in the absence of successful treatment, go on to develop other psychiatric disorders.

Therefore, the aim of the present research is to develop a suitable method or strategy by which the aged resident can minimise the adjustment reaction which has been precipitated by the process of institutionalization. A review of the literature up to the present, demonstrates that many such programs have been initiated on an ad hoc basis and seldom exhibit a clear, systematic rationale. It can be argued that a treatment approach derived from a specific theory is extremely beneficial in drawing the therapist's attention to the relevant issues that need working on; whereas simply applying psychotherapeutic techniques in a randomised fashion does not allow one to predict which treatment approach is useful.

Crisis Theory, like general systems theory, represents a core conceptual tool in preventative mental health work. Crisis concepts have advanced our understanding of problems of personality development and change

and as such, the body of knowledge provides the clinician with an adequate means of aiding the aged in their attempts to integrate the experience of being placed in an institution or residential setting.

Golan (1978) sums up the basic tenets upon which crisis theory is predicated as follows :

- (1) Crisis situations may occur episodically throughout the normal life-span of individuals, groups and nations. They are usually initiated by some hazardous event, which may be a finite, external stressful blow or some less bounded internal pressure. It may be a single catastrophic occurrence or a series of successive mishaps which build up a cumulative effect.
- (2) The impact of the hazardous event disturbs the individual's homeostasis and puts him in a vulnerable state.
- (3) If the problem cannot be resolved or redefined, tension reaches a peak and a precipitating factor can bring about a turning point during which the individual enters a state of disequilibrium and disorganization - a state of active crisis.
- (4) The individual may perceive the stressful event as a challenge, a loss or a threat.
- (5) Each of these perceptions calls forth a characteristic emotional reaction - moderate anxiety and hope, depression and mourning, and high anxiety, respectively.
- (6) A crisis situation is neither an illness nor a pathological experience. It reflects a realistic struggle in the individual's current life situation.
- (7) Each particular type of crisis follows a series of predictable stages. Emotional reactions and behavioural responses at each stage can be generally anticipated. Fixation or admission of a

stage may provide the clue as to where a person is "stuck".

(8) Although the total length of time between the initial blow and the final resolution of the crisis may vary, the actual state of active disequilibrium is time-limited, usually lasting up to four to six weeks. (It is precisely because of this that crisis intervention is explicitly time-limited).

(9) During the resolution of the crisis, the individual tends to be particularly amenable to help. The ego becomes more open to outside influences and change.

(10) During the reintegration phase, new ego sets may emerge and new adaptive styles learned which will enable the person to cope more effectively in the future. However, if help is not available, inadequate or maladaptive patterns may be adopted. (pp.7-9)

Crisis Intervention, which is a set of techniques predicated on Crisis Theory, attempts to promote some form of amelioration from the negative stereotypes of loss. It is one of today's most widely used forms of mental health treatment. It consists of a short-term psychotherapy programme usually lasting no more than five weeks. It is designed to help individuals (who have experienced severe stress) to cope. Ewing (1978) believes that crisis intervention serves not only to aid in solving present problems, but also to prepare clients to master further vicissitudes through the development of more effective adaptive coping mechanisms. Therefore the therapist's principal role is to promote growth. Hirschowitz (1972) believes that the individual who copes well has some of the following characteristics :

He is able to deal simultaneously with the affective dimensions of his experience, and the instrumental tasks with which he is

confronted. He is aware of painful emotions and gives appropriate expression to them. However, he does not engage in interminable catharsis or ventilation. As he expresses his painful emotions and communicates his suffering, he frees energy for mastery of his environmental challenge. Crisis mastery proceeds by the conversion of environmental uncertainty into manageable risk. We consider this process of situational mastery to be crucial and think of it as intelligent worry work (p.119).

Healthy crisis coping is further characterised by an ability to acknowledge and communicate increased dependency needs. Assistance can be sought, received and used. Furthermore, attendant value is placed upon understanding, personal growth and discovery learning. In coping with anxiety, the individual resorts to defences and patterns of tension release which are not destructive of their consequences.

As we have argued, application and admission to an aged home constitute a major life crisis for the old person and family members with each phase having its own set of stresses. Many losses have already been experienced and others are imminent: physical and/or mental decrements; interpersonal losses of family and friends; loss of former occupation and activities; the familiar environment of home and possessions; degree of autonomy or independence, and economic status.

It can be argued that crisis intervention with all its techniques is a logical method of treating the above symptoms. It is the author's opinion that newcomers to aged residential settings should be granted the opportunity to ventilate and work through their feelings about institutionalization. "By listening through and looking beyond the verbalized complaint, it is possible to apprehend the client's non verbal

anxiety or pain. The ability of the therapist to find the hidden pain is what gives the client a feeling of being truly understood" (Hoffman & Rummel, 1975).

Admission to a geriatric institution precipitates an increase in the resident's anxiety, hostility, belligerence and dependency. Therefore a goal that should permeate every step of institutional care should be to help the older resident resolve his/her grief and anger, accept new goals and maintain and regain mastery to the fullest possible extent. To do so, his/her previous personality patterns, strengths and other aspects of functioning should be understood, emphasized, and exploited. The approach is to support maximum functioning - physical, psychological and social - in the interest of the mental health of the older person and family members.

Morley, Messick and Aguilera (1967) have found the following techniques in crisis intervention to be the most productive :

(a) Helping the individual to gain an intellectual understanding of his/her crisis: Surprisingly frequently a person in crisis may have no idea that there is a relationship between a hazardous situation which has occurred in life and the extreme discomfort which he is experiencing at the time he/she comes in for treatment.

(b) Helping the consultee to bring into the open his/her present feelings to which he/she may not have access: Not only may the consultee be unaware of the relationship between the precipitating event in his/her life and the discomfort which he/she is feeling, he/she may also not have allowed himself/herself to experience some of his/her real feelings.

(c) Exploration of coping mechanisms: With this approach, the person will be asked to look at alternate ways of behaving. Behaviours

he/she has used for reducing anxiety in the past may not be utilized for some reason, and the possibility of introducing these mechanisms is explored. In addition, new coping mechanisms are explored.

(d) Reopening the social world: Typically, when there has been the loss of a significant person in an individual's life, exploring the possibility of his/her introducing new people into his/her social orbit may be highly effective.

As the individual's coping ability has increased during the course of intervention, and as a reduction in his/her anxiety and depression has occurred, the consultant makes every effort to reinforce the changes. This may involve summarising the adjustments which have occurred, and allowing the person to re-experience the gains which he/she has made. Help is also given in making realistic plans for the future, and specific methods of warding-off future crises are discussed.

Using Hollis' classificatory system, Golan (1978) outlines the following techniques that the crisis intervenor should apply:

(a) Sustainment, Ventilation: During the initial phase of treatment of a crisis situation, the use of sustainment techniques designed to lower anxiety, guilt, and tension, and to provide emotional support, is an important aspect of the development of the client-worker relationship aimed at restoring equilibrium. Techniques of reassurance, encouragement and sympathetic listening demonstrate the worker's active concern and sustain the client's feeling of being cared for. At the other end of the sustainment continuum is ventilation on the client's part. "Getting it off one's chest" is a basic procedure in the early stages of crisis

intervention and it becomes helpful in working through bottled-up feelings of anger, frustration, grief and loss.

(b) Direct Influence: Procedures of direct influence, designed to promote specific kinds of changes in the client's behaviour are probably used more often in crisis intervention than in other types of direct treatment. Advice giving is frequently and appropriately used during periods of active crisis, particularly when the client is feeling overwhelmed by what has happened and needs guidance in choosing a course of action and assuming unaccustomed roles. Advocating a particular course of action and warning clients of consequences can be very effective with confused, bewildered or depressed clients.

(c) Person-Situation Reflection: As the client's anxiety level becomes reduced and he begins to view the picture more objectively, the therapist engages him in reflective discussion of his current situation and of his recent past after the advent of the hazardous event. Three aspects are focused on. First, the information he has on the objective reality: Does he see the picture clearly and realistically? Does he have all the facts or is his grasp of the situation distorted by his own emotions or prejudices? The second aspect deals with the person's interaction with the objective situation. Does he grasp what his choices of action are in view of the recently changed situation? The consequences (to himself and to others) of the decisions and actions he might take at this time are the gist of the worker-client discussions in this area. Helping the client to examine the alternatives, to make a choice and to embark on an appropriate course of activity, can set a new pattern for constructive coping.

with similar difficulties in the future.

Finally, the worker can help the client to examine introspectively his own part in the situation in order to help him gain awareness of his own emotional reactions to the total crisis complex. Facilitating the process in which the client gets "in touch with himself" and bringing such feelings into the open for joint examination is a predominant feature of crisis intervention.

(d) Dynamic and Developmental Understanding: Reflective consideration of life experiences which have influenced the client in the past and are still affecting him in the present, is usually undertaken in an episodic way. Specific themes such as loss, loneliness or fear of authority can be explored in terms of how they have shaped current reactions. This is the prelude to breaking the inappropriate linkages between past and present which may be a prominent feature of active crisis states ... (pp.98-103)

In summary, crisis intervention involves the following techniques:

- (1) Helping the individual to gain an intellectual understanding of his crisis situation.
- (2) Helping the individual to bring into the open those feelings to which he may not have access.
- (3) Exploration of coping mechanisms.
- (4) Reopening his social world.
- (5) Future/anticipatory guidance/planning.
- (6) Confrontation at a reflective level.
- (7) Explanation of treatment to client.
- (8) Giving information in a didactic manner.
- (9) Realistic support and honesty.
- (10) Making him aware of his responsibility for himself.

4.1 The Problems Posed by This Study :

As we have demonstrated, Crisis Theory and Crisis Intervention offer a clear understanding of, and provide the appropriate treatment method for, the adjustment reaction of newcomers to residential settings for the aged. However, there seems to be some dispute as to when the actual crisis begins.

Lieberman et al (1976) argue that the crisis is initiated once one decides to seek institutionalization as an alternative. "Our findings suggest that reactions or effects occur in response to meanings of loss and anticipated loss and not to events that precipitated admission" (p.218). In view of these findings, it seems apparent that after the decision to embark upon institutionalization is taken, the older resident-to-be, as well as the family is in a state of crisis. Family members feel guilty and the older person feels rejected, abandoned and often enraged.

One may argue that the turmoil engendered by the decision to institutionalize an aged resident can be alleviated by thorough preparation. Preparation for admission is usually thought of in terms of information about and exposure to the future situation. Apparently a sound appraisal of one's situation including knowledge about the institution, is beneficial for the resident-to-be, whereas avoiding dealing with the impending event is not. Exposure to the future environment, visiting the institution and meeting with some of the residents may be seen as a vital step in enhancing successful adaptation at a later stage.

A study by Dominick, Greenblott, and Stotsky (1968) yielded information concerning the value of preparation. The authors attempt to identify some of the variables which were related to successful adjustment of individuals placed in nursing homes from either mental hospitals, general hospitals, or their own homes. One of the findings of this study

in the interpersonal arena. They suggested that this difference may be due to an amelioration of the crisis-related reactions encountered during the waiting-list period.

Brody (1974) stipulated that :

... sustaining the relationship between institution and clients during the waiting period is of value. The social worker should invite and periodically initiate telephone or person contacts in order to provide reassurance of the institution's continuing awareness of their need for admission, to offer to help with new emergencies which arise, to keep abreast of the changing condition and needs of applicant and family, and to give continuing case-work (p.284).

If we accept that both the request for permanent residence to an institution as well as the waiting period prior to final placement marks a change in the ecological balance, then it is theoretically plausible to provide primary crisis intervention to the prospective new resident before he/she enters his/her last home. Following this rationale, some geriatricians have simply applied crisis intervention techniques to the resident prior to admission.

Be that as it may, the present author believes that a strong argument can be made for the fact that the most severe crisis in the continuum of institutionalizing an aged citizen takes place with the act of admission to the particular residential setting. A state of active crisis, wherein one's homeostatic mechanisms are broken down, is ushered in by the admission to the institution in question. To quote Lieberman (1976), "Only when the resident-to-be is actually a resident in the home will he or she meet the full impact of a foreign world with all its attendant consequences and meanings" (p.232). Only once the initial impact of entering and living in the institution has been weathered, can the new resident go beyond merely accommodating to the foreign world.

Golan (1978) believes that active crisis is the key aspect in crisis theory, and should be the determining factor in the decision as to whether or not to use the crisis approach as the treatment of choice. Korner (1973) points out that when a person undergoes a sudden change in the social environment, there is an explosive release of emotions which overwhelms the available coping mechanism. Caplan (1964) estimated that the actual stage of imbalance usually lasts for only four to six weeks. During this period, the person passes through a series of predictable reactions. First, psychological and physical turmoil occur, including aimless activity or even immobilisation, disturbances in body functions, mood, mental content, and intellectual functioning. This upset is followed and accompanied by painful pre-occupation with events leading to the state of crisis. Finally, comes a period of gradual re-adjustment and remobilisation as the individual becomes attuned to the altered situation.

Following this rationale, there is then a strong case for employing ameliorative procedures when the individual is experiencing the height of crisis. Therefore one of the principal objectives in this research is to include a crisis intervention program to alleviate symptoms of the adjustment reaction posed by entering a residential setting. Our objectives are to give the newcomer meaning through dignity, enrichment and enjoyment, thereby countering the negative effects of entering an institution. We aim to emphasise the positive or existing potential by reinforcing assertiveness, self-determination and creativity, as well as promoting opportunities for the continuity of social roles. This approach is not plagued by simply focusing on the negative effects of impending institutionalization, of which so much has been written but rather to build on healthy areas. A sense of autonomy and control over

one's destiny are overriding factors conducive to mental health; apathy results when they are lost or lacking. The collapse of self-determination, the need to turn to others for care and the surrender of the direction of one's personal life are among the most profound negative effects of institutionalization.

Let us assume that we carry out an intensive crisis intervention program for five weeks and we get a positive outcome, that is to say there is a marked reduction in the symptoms that were presented on admission by our newly admitted aged residents. Can we then conclude that the therapy itself has been responsible for the alleviation of stress engendered by entering a residential setting?

Methodologically speaking it is possible to argue that improvement has nothing to do with the content of the therapy per se, but simply reflects the development of a relationship involving social attachment between client and therapist, at a time in the aged resident's life when he/she is most needy. Therefore it may well be the case that through the activity of social communication, it is possible to facilitate a process of continued growth. Perhaps it is the human contact that is so vital in helping the aged person deal with the effects of geographic and social distance from his/her family and friends. Normally, during the process of institutionalization one becomes extremely lonely especially when one is totally surrounded by strangers and therefore any meaningful, regular contact with a person serves to promote a new relationship.

Maslow (1962) believes that we develop our highest potential as human beings only when certain social and emotional needs are met. He lists these as our need for health and safety, belonging and affection, respect and self-respect, self-actualization, and significance. These basic needs can only be met through our relationships with other human beings whose lives and love confirm us. He points out that it is

essential for our continuing mental health to make new relationships to replace those that are lost by death or other reasons, but these new relationships may have a different quality from those we made in early life periods that gave so much meaning to our lives. To make new and intimate friends when one is old is not easy, especially so when living in an institution as here there is a marked tenuousness of new relationships. "Living without the stimulation of close contact with caring people will only increase our loneliness and depression and accelerate degenerative changes in our minds and bodies" (Vickery, 1978, p.82). Therefore, having a close relationship with someone during one's first month in a new environment may serve to counterbalance many of the deleterious effects.

One may alternatively hypothesise that an ongoing social activity may aid in de-emphasising the destructive consequences of having one's identity stripped by the total environment (Goffman, 1961). As early as 1953, Havighurst, Albrech and Cavan suggested the health and well being of the aged was closely related to the physiological, psychological and social activity levels of the aging adult. Such dimensions were considered in a state of dynamic tension so that reduction in activity levels in one area inevitably meant decrements in others. Therefore if one perceives institutionalization as a deprivation in the levels of one's ongoing social contact and activity, one may hypothesise that it is a reduction in this level of activity that contributes to the greying portrait of the elderly who are admitted to aged homes. Alternatively, one may perceive this activity as a means of re-engaging the aged individual in meaningful interaction. Vickery (1978) postulated :

Experiences that leave us physically handicapped cause some of us to give up on life and decide that it is enough just to stay alive

and be fed and cared for by others. This kind of petering out seems like such a tragic way to end our long adventure. If we are able to make the transition from the deprivations that our own personal tragedies have brought and accept re-engagement of our minds and spirits and what physical functioning is still ours then the inner flow of our vibrancy and integrity may remain (p.107).

Havighurst, Neugarten and Tobin (1968) have posited the notion of social disengagement to explain the process by which one reduces the number of interactions and roles. Becoming institutionalized typifies the disengaged position and many aged homes have developed rehabilitation programs which aim at resocialising the new resident. Parsons (1951) defines resocialisation as an interactive process undertaken at a life-stage after childhood, utilising socialisers to assist new members of the social system to learn new life patterns and to gain the knowledge necessary to function within the social system. This involves a "network of interactive relationships" in which instrumental and expressive influences may be involved in any combination. Bennett and Nahemov (1965) reported that the more social contacts an individual had prior to entry into a home for the aged, the more successful he later was at learning the norms of the institution. They also found that pre-entry isolation affected a resident's initial as well as long-term adjustment and that those new-comers to a home for the aged who were quickly socialised, reflected better adjustment on both a short-term and long-term basis. Conversely, those who were not socialised at the start of their stay, continued their isolation, thus perpetuating the desocialisation process. The findings seem to indicate that early socialisation is crucial to bringing about subsequent adjustment and that it is a most persistent

predictor of long-term integration into activities by residents of a home for the aged.

Following this rationale, it is the author's intention to provide some newcomers with the chance to have access to a relationship with a trained volunteer in which both attachment and resocialisation are emphasised through the medium of social activity. Here the new resident's specific interests and activities are explored, reinforced and an attempt is made to continue previous activities, both in and outside the home, as well as facilitating and matching the newcomer's interests with the services and activities offered in the home. In the cases where new residents do not have sufficient interests and goals and are isolated and apathetic as regards social activities, the volunteer will motivate and encourage social participation. This is to be done by informing appropriate staff members (when and where necessary) so as to extend continuity in the volunteer's absence.

This treatment approach is included to investigate whether specific therapy is necessary in aiding adjustment. It may be argued that all that is necessary is facilitating a less traumatic adjustment, is to have a member of the community show care and concern and help in the resocialisation process, thereby reducing the total severing of contact with mainstream community life. The comparison between curative and attachment approaches is therefore strongly indicated if we are to draw any meaningful comparisons as to which treatment alternative is the most effective in resocialising newcomers to residential settings for the aged.

Alternatively, one may argue that adjustment to an aged home is largely influenced by personality factors, irrespective of what treatment approaches one uses. The assumption is that those aged with pre-institutional personality traits that are congruent with the specific demands of the relocation environment will experience a minimum of distress due

to relocation. Such congruent personality traits may facilitate adaptation because the impact of relocation is lessened when there is a relationship between traits and specific demands of the environment.

A relationship between personality traits and situational demands has been reported for several settings. For example, in a report of adaptation to concentration camp internment, Wolf and Ripley (1947) suggested that a predisposition toward psychopathological ruthlessness maximised the chances of survival. Previous literature on institutionalization (Goffman, 1961; Martin, 1955; Sommer and Osmond, 1960; Townsend, 1962) had suggested several dimensions of potential importance for adaptation, such as activity-passivity and trust-mistrust of others. Turner et al (1972) in a study investigating personality traits as predictors of institutional adaption among the aged, found that for the individual undergoing the stress of institutional adaptation, congruent traits facilitate positive adaptation. Most likely the initial impact of the stress or event is less of a psychological stressor for these congruent individuals. If, however, the adaptational style of the person undergoing a radical environmental change is consistent with the style rewarded in the new environment, then for this person it may be less of a radical psychological change, and thus there would be less of a subjective experience of the potentially stressful event, as well as less adverse psychological effects ...

The particular trait found to be associated with successful institutional adaptation in this study loaded highly on activity, aggression and narcissistic body image. This cluster of traits suggests that a vigorous, if not combative, style is facilitory for adaptation. It is a style of being intrusive into the environment: of actively seeking interaction, of aggressively relating, and of

insisting on responsivity from others regarding physical attractiveness. At a more covert level, it suggests a narcissistic-hostile and controlling orientation toward the institutional environment (Turner et al, 1972, p.68).

Perhaps one's adjustment depends on one's ability to accept the limitations of the home. The Home is a multi-functional agency, it is a social agency, semi-hospital, living arrangement, rehabilitation centre, and religious institution. As such, it is not only complex, but unable to be all things to all people. Once the basic fears which led the resident to enter the home are alleviated, new problems arise which are inherent in group living. Can the resident take the denial of some of his/her requests, is this seen as something personal, or can he/she accept the explanations when given?

Then again, adjustment may reflect the newcomer's ability to accept the present living arrangement. Residents often come feeling a great rejection and see the home as a place of no return. To what extent does the resident realistically accept and enjoy the home; to what extent does he/she strive for a better life in the home; to what extent does he/she accept change in the home based on his/her need? These are all crucial questions that one needs to answer when considering adjustment.

Health factors are directly related to one's adjustment to a new environment. The decrements in function which come with physiological breakdown present many threats, and adjustments to the older person. It is possible to argue that the more physically and mentally impaired one is, the less likely one is able to negotiate the crisis imposed by relocation.

Perhaps attitudes toward one's family and friends are crucial variables in the adjustment process. The resident is in a dynamic

relationship with his family and relatives and friends of old, while in a new setting with new friends and family substitutes or surrogates.

Important questions to be considered are: Does the resident continue a relationship with his family? Has the relationship improved? Is there a better attitude on the part of the family toward the aged relative now in the home? Does the resident feel his family and friends have forsaken and rejected him? Has he severed previously existing ties with family and friends?

The financial status and affluence of the resident may be a factor in how he/she adjusts. Does money bring the right to service, does it influence one's feelings of superiority or inferiority over others? In the final analysis, the problem posed by this research is of a two-fold nature:

- (a) Which treatment alternative is likely to be most successful in minimising the adjustment reaction of aged residents?
- (b) Is the outcome of one's adjustment reaction likely to depend purely on the treatment alternative applied or do confounding variables such as personality traits, institutional effects, sex, age, health, socio-economic and social criteria, as well as financial status, all cloud the issue?

4.2 Inter-relationship between Present Research Objectives and Gerontological Theory.

The theoretical concept of Disengagement, described by Cumming and Henry (1961) has served as the backdrop for gerontologists to explain the reason as to why so many aged citizens retreat to institutional settings. The most controversial aspect of disengagement theory is not the occurrence

of disengagement but the interpretation of the Cumming and Henry finding that disengagement is positively related to optimum successful aging. Subsequent research ran counter to these results. (Maddox, 1963, 1965).

We have highlighted the fact that withdrawal is not the way to negotiate the crisis of institutionalization, but it is rather responsible for many of the negative effects. Alternatively, we believe the only way to meaningfully rehabilitate an aged new-comer to a residential home is to facilitate a process whereby strong affective reinvolvements are enhanced. That is to say, we aim at giving potential residents the resources to develop new attachments.

The concept of attachment has received considerable attention among infant and child psychologists but as yet has only received marginal attention from gerontologists. At this juncture, the author believes that the concept of attachment offers a life span developmental view which is more meaningful and less self limiting than that of disengagement. Perhaps the concept of disengagement is no longer functional and it should be eliminated.

Conventional definitions of attachment are usually restricted to the establishment of social bonds. Although attachment theorists often state that many persons can be the objects of an attachment relationship for any given individual, the overwhelming emphasis of both theory and research has been on the mother-infant dyad (Bowlby, 1958). In a life span perspective, however, the term can be used in a broader context. Kalish & Knudston (1976) describe the potential usefulness of the concept of attachment in providing a conceptual schema for understanding relationships and involvements of older persons. They suggest that the concept of disengagement be eliminated and that gerontologists as well as life span developmental psychologists focus instead on attachments of the elderly in order to gain a new understanding of the continuities and

discontinuities in attachments across the life span, particularly in old age.

At this point, we must emphasise the difference between attachment and contact ...

"The former implies a moderate or, in most instances, a strong affective involvement with the attachment object, the latter presupposes merely that a social interaction has occurred or that a belief or idea is (held) or claimed or that something is owned or, in the case of a place, is familiar and has been appropriately experienced" (ibid, p.172).

By now, the reader will be familiar with the fact that in old age, mastery and control begin to diminish, while vulnerability increases. What is more, the early objects of attachment have disappeared. Parents and other early significant persons have, for the most part, died, frequently arousing a sense of increased impotence. Mutual attachments with adult children, although present, are greatly enriching, but physical space, busy schedules, and family tensions often keep their effectiveness to a minimum. Old friends die, familiar things disappear and even the ideas and belief systems to which they were socialised, have taken on a different significance. These losses of attachment objects tend to come with a rush at points of transition such as retirement and/or loss of spouse; often producing maladaptive coping mechanisms.

When very old age, or ill health occurs, the power balance alters again, with the old person finding his control of the situation severely limited.

"... The strong and comforting people who once nurtured you are in need of your strength and comfort. The roles are reversed.

Your parents now seem like your children: dependent, demanding, needing more, perhaps, than you can give. In many ways your children are easier to handle" (Grollman & Grollman, 1978, p.3).

Similarly, relationships with age peers, including spouses, become governed by availability. Aged individuals have a diminishing circle of people who are important to them. Death robs them of siblings, other relatives, colleagues, friends, a spouse, and even sometimes a child.

With whom then do the elderly form attachments? When new relationships are formed they are often contractual and involve the physician, the nurse or the welfare worker, who provide care-giving rather than emotional support. These new attachments are often much weaker than earlier attachments and frequently are not mutual. They are, therefore, much more likely to be broken if the older person is not 'good', since neither the attachment with the physician nor the aged home director has the history of involvement that is found between parent and child, and reciprocity is based on care-giver role requirements, not on familial responsibility or affection.

This revived fear of abandonment and separation is basic when the elderly person faces institutionalization. Goldfarb (1969) claims that in situations such as these, the aged attempt to cope through dependency behaviour whereby they try to manipulate a stronger person into caring for them. Others adapt to their limitations by withdrawing and some display childish behaviour. In order to explain this process, the notion of disengagement was posited.

The process of disengagement can be understood as being based on a simultaneous devaluation of attachments, so that the elder person and his social milieu withdraw from each other in terms of the number

of contacts and the strengths of the attachment bonds. The timing of this disengagement seems largely dependent on when the elderly person feels no longer able to generate meaningful social feedback from his actions. Without such meaningful feedback, the attachments and social bonding on which they are based, weaken (ibid, p.176).

Although the Disengagement Theory has been of major importance to gerontologists in the past, its prescriptive implications, more recently, have tended to reinforce negative attitudes on people working with the aged. That is to say it has influenced the attitudes of professional workers to reinforce the helpless position bestowed upon our aged citizens by the society at large. It serves to take responsibility away from the citizen, and leaves him/her in an undignified powerless state, waiting for the welfare of others. By using the concept of attachment, we allow the scales to be tipped back to equilibrium with the older person being perceived as having a part to play in what happens to him. No longer is the aged citizen seen as a passive recipient of environmental forces but rather is considered to be in a dynamic relationship so that every time behaviour is initiated, the environment responds to provide feedback to the individual, which is then interpreted by him as part of the process that influences subsequent behaviour. Kalish & Knudson (1976) believe that one necessary interpersonal/personal environmental condition that must be met for attachment to occur, is that of self produced feedback.

Lowenthal & Haven (1968) found that having a confidant appeared to discriminate between elderly persons who were institutionalized and those who could remain in the community. Losing the confidant resulted in depression and detachment from the social world. The very nature of

the role of confidant suggests a highly reinforcing feedback system. In the present research we have attempted to recreate a situation whereby the relationship with a psychotherapist or volunteer can serve to give the newcomer the opportunity to develop a meaningful attachment. In both cases, the worker's specific objective is aimed to enhance the attaching person's ability to control or master the environment. In so doing, the person needs someone to talk to, someone with whom he/she can safely share feelings and thoughts, without interruption even if in some instances, tangential thinking is apparent. Praise and acknowledgment are to be given freely in an attempt to reassure the person that he/she is still valued, respected and admired. Therefore, we hope to contribute to the development of this new theoretical perspective in gerontology. Hopefully, this study is just one example of how the application of an expanded version of attachment theory can integrate significant findings in the gerontological literature.

4.3 The Need for Gerontological Research in The South African Context :

South Africa, in common with the rest of the world, will in future have to deal with a much bigger "old-age problem" as its community of senior citizens increases. The facts give ample proof: the life expectancy for a white man in South Africa in 1920 was 55,6 years; his wife could expect to live to 59. In 1970 ages had increased to 65 for males and 72,9 for females. Today they can hope to live even longer.

The number of over-sixty men and women relative to the total population is growing fast: in 1921, five in every 100 white persons in South Africa were over 60. It is estimated that 10 of the white population are senior citizens, and the forecast is they will increase to 16 by 2020. Table 1 indicates the rise in the population of

over 60-year-olds by the year 2020.

Table 1

THE AGED POPULATIONS OF SOUTH AFRICA						
1970	1980	1990	2000	2010	2020	
156	340	401	452	578	736	WHITES
61	79	101	145	205	316	COLOURED
12	19	29	45	73	120	ASIAN
517	433	851	1238	1780	2694	BLACK
746	871	1382	1880	2636	3866	TOTALS

The total population, taking all race groups into account, is expected to increase from about 1 340 000 over-60 men and women now, to 5 930 000 in 2020, (To The Point, 27 April, 1979).

Most nations have been caught unawares in preparing their taxes, welfare and manpower machinery to cope with a similar avalanche. The question remains as to how well South Africa is geared to meet this need now and in the future - for its black as well as white population.

In attempting to answer this question the author will concentrate briefly on community services and facilities offered. Since 1956, the S.A. National Council with its affiliated organizations has endeavoured to give special attention to the needs of the aged to enable them to preserve their self reliance and to provide the means for years of fruitful contentment. The aged are in need of facilities whereby they can form meaningful friendships and have opportunities for interaction and where,

through medium of social interaction, they can experience life satisfaction (Droskie, 1978)

A network of facilities, programmes and services must be available to aged citizens to enable them to deal with short-term crises as well as to develop long-term goals. One may well argue that without these supports many of the older generation lose the capacity to live independently. Droskie (1978) postulates that many facilities should be provided by a centre to which the aged can come for a variety of activities and services. Such a centre should also serve as the base from which various services are delivered to elderly in the community. She claims that some of the services a centre should offer are, meals on wheels for those who are housebound, health clinics attended by a geriatric sister and doctor where necessary, library services, educational programmes, home help services, group work and handicrafts and recreational facilities.

For the purposes of this study, we are particularly interested in institutional care. The latest figures available concerning the number of institutions for the aged are as follows:

<u>White Aged</u>		<u>Number of Beds</u>
Registered Homes	292	19 245
Registered Private Homes	85	3 447
Dept. Social Welfare & Pensions	4	360
Private firm Smith-Mitchell	4	388
<u>Coloured Aged</u>		
Registered sub-economic Homes	17	1 079
<u>Indian Homes</u>		
Registered sub-economic Homes	2	78
<u>Homes for Blacks</u>	16	1 443

(ibid, p.7. 1978)

Looking at white aged homes in the Western Cape, current figures reveal that there are 1 210 white residents in sub-economic homes, whereas the number of residents in economic homes is 281. These figures do not include the number of residents in private homes.

The admission criteria to homes for the aged are completely unstandardised at present. Droskie (1978) believes that people should be admitted when in need of care and attention. Because this is not done in any uniform manner, many organizations fail in the service they render to the aged. In a previous study the author compared and contrasted geriatric first admissions to a State Mental Hospital and to an Old Age Nursing Home. The common sense prediction suggests that residents in a state mental hospital should be more psychiatrically disturbed, whereas residents in the old age nursing home should be physically disabled and lack adequate social support to sustain themselves in the community. The aim of the study was to examine whether this prediction holds true in the case of first admissions. A total of 50 subjects from both populations was assessed on biological, psychological and social parameters. Contrary to what was expected, first admissions to the mental hospital, apart from a higher incidence of organic brain syndrome, did not demonstrate more psychopathological symptoms. Similarly, first admissions to an aged nursing home did not display the expected degree of physical morbidity and in fact, presented with more affective disturbances (anxiety, depressions and hostility). Currently, it appears that within the traditional old age nursing home setting, no adequate facilities exist for the treatment of the high incidence of affective disturbances revealed in this study (Joffe, 1978).

Affective disturbances, particularly depressions, are the most frequent functional psychiatric disorders in the later years (Busse, 1961;

Kay et al, 1964) and a principal reason for hospitalisation. It is therefore surprising that one does not find a significant difference between the two populations in the direction of more affectively disturbed individuals being admitted to a mental institution. How does one reconcile the fact that the situation is reversed? Lieberman and Tobin (1976) claim that the institutionalization process for people who are likely to be moving for the last time in their lives is so traumatic that it causes people to undergo profound psychological alterations. The manifest consequences of this acute experience have often been labelled 'the first month syndrome'. Therefore, to all intents and purposes this disparity may simply reflect the signs of a severe adjustment reaction.

Little or no formalised treatment exists in Cape Town to promote adjustment for aged new-comers to residential settings. Most of the staff are unaware of the severity of the adjustment reaction and in the final analysis, the new resident is left to meander his/her way along the proverbial institutional path, often suffering unnecessary psychological discomfort. The need for exploratory research in aged homes is therefore markedly apparent, as this is the location or seat of many problems. A number of very difficult old people reside within these settings, and administrative staff have found it impossible to deal with them. These residents are maladjusted, impossible to live with and have the knack of making everybody they come into contact with, unhappy. Much as one is aware of their needs, it is not practical to upset all the other residents in a home by accommodating this type and many are referred for psychiatric help.

In a recent study by Gillis et al (1979), investigating the reasons why old people were admitted to a mental hospital, the main psychiatric symptoms which precipitated admission were depression, confusion, dementia

and a past history of psychiatric illness. The most striking finding however, was in relation to old age homes. Even granted that they deal with older and more mentally and physically frail people, a disproportionate amount of hospital admissions came from this source and many of these patients were suffering from preventable and easily treatable conditions that had been missed or labelled incorrectly. The homes only tend to refer their most difficult "management problems" and in many instances, the project psychiatrist, clinical psychologist and psychiatric social worker felt that a primary diagnosis of depressive illness had been missed with respect to these patients. By and large, it was our impression that this was due to a low standard of routine care and inadequate selection procedures. If one is only seeing the more difficult cases, one may well imagine how much psychopathology is being missed, especially with regard to the more tractable depressed cases in which unassertive, confused residents are simply forced to withdraw and suffer in silence.

It is well known that psychopathology in aged homes is quite substantial. Goldfarb (1957) found that old age homes do not necessarily serve only social and retirement needs. Over fifty per cent of their beds are of the infirmary type, caring for physically and mentally disabled residents. Unfortunately, most of the homes in South Africa have fallen prey to the custodial attitudes of the last century and little or no active psychological intervention is available to the needy population who frequent these localities.

Newcomers have the "right to treatment", which in essence must involve a thorough assessment for each patient. Preliminary diagnostic formulation and individualised treatment plans should be accomplished within the first week of admission to a residential facility so that a

smooth adjustment and integration into the new home can be facilitated. Yet most of our aged homes serve to unintentionally alienate many residents. The many and pervasive aspects of authoritarianism seen today are facets of infantilization and serve the needs of the providers rather than those of the residents. The fewest restrictive conditions necessary to achieve compliance should be reinforced, and rather the resident should be encouraged and assisted to exercise his/her rights as a citizen. To this end, the newcomer should be allowed to voice grievances and recommend changes in policies and services to facility staff and/or to outside representatives of his/her choice free from restraint, interference, coercion, discrimination, or reprisal.

Perhaps this is for the present time too idealistic, therefore it is simply the author's explicit intention to minimize the adjustment reactions that newcomers experience when entering aged homes. With this philosophy in mind, the present study examines the effects of admission to a representative sample of aged homes in the Western Cape by comparing and contrasting the progress of three groups of aged residents during their first three months of residency. Two of these groups have specific treatment objectives that are employed to decrease the stress engendered by moving into what surely is, one's last home. The first group involves a five-week crisis intervention program, whereas the second includes the development of an attachment relationship with a community volunteer over a five-week period through the medium of social activity. The third group serves as a control in that no intervention is offered during the first three months of residency. The objective of the present research is to determine whether either of the two treatments is effective in decreasing or minimising the stress produced by entering an aged home. Ancillary aims are to assess whether adjustment is in any way affected by premorbid personality traits,

institutional effects, age, health, socioeconomic criteria, and financial status.

Adjustment is an extremely difficult concept to measure. Too frequently, social scientists view adjustment or mental health in terms of a lesser degree of pathology or a low score on a mental illness scale. The use of these methods as the sole criteria of mental health has been severely criticised (Hacker, Gaitz & Hacker, 1972; Neugarten, Havighurst & Tobin, 1961). These authors suggest that any evaluation of an individual's mental status should include measures of mental strength and mental weakness.

The present author believes it is important to go one step further, that is to say, one must study adjustment from a multi-dimensional standpoint. The dialectical method provides us with such a framework. It is a new theoretical force in psychology which has particular relevance to the study of gerontology, and can be clearly understood by contrasting it with three levels of psychological research.

(1) The oldest and still rather common path is used by general-experimental psychologists. This approach is the most abstract form of scientific inquiry. Both individual-developmental and cultural historical changes are eliminated. Riegel (1977) suggests that such a model represents the human being as a fictitious point in a historical vacuum.

(2) Although developmental psychologists have studied age differences and sometimes changes, most have eliminated cultural-historical changes from consideration ...

For example young and old persons tested at one particular time differ widely with regard to the cultural-sociological conditions under which they grew up. Although the impact of historical changes during an extended period of time, e.g., in education, health care, nutrition, communication, etc., is often much more dramatic than

any behavioural differences between young and old persons, this factor has been disregarded in all but a few developmental studies (Riegel, 1977, p.72).

- (3) The third approach examines changes and interactions of events within and between individuals ...

In recognizing the code determination of experience and action by inner-biological and cultural sociological changes, dialectical theory de-emphasized individual psychology development in the traditional abstract sense. Instead it focuses upon concrete human beings and the gradual modifications (neurological, physiological) or sudden shifts (accidents, diseases) in their biological make-up that force them to change constructively their individual-psychological operations and, thereby, also the social conditions under which they live. At the same time, a dialectical interpretation focuses upon gradual modifications (increase in available time) or sudden shifts (birth of children, promotion, loss of friends) in the cultural-sociological conditions that force the human beings to change constructively their individual-psychological operations and, thereby, their inner-biological state. Thus, individual-psychological development is seen in its intimate and mutual determination by inner-biological and cultural sociological shifts and changes (ibid p.87-88).

The dialectical method of analysis applied dialectical logic (Novak, 1969) to a behavioural event. The primary emphasis of this method centres on activity and change, rather than on stability and permanence. Behaviour is located in a time/experience continuum. Dialectical operations may take the form of a dialogue between individuals, or a dialogue within

the individual. A dialectical theory emphasizes contradictions and their syntheses in short and long-term development in the individual, in society and between the two (Riegel, 1976). The conflicts between developmental dimensions (biological, psychological, social, environmental) are thought to be the impetus behind life span development, including development in old age (Riegel, 1976, 1977 a, b). The individual develops in the context of several aspects or dimensions of individual and social life. Responses are categorized into the following developmental dimensions (1) biological dimension (health considerations); (2) psychological dimension (wants, needs, - in terms of personality and continuity, emotional factors, stress, attitudes, interpersonal events); (3) social dimension (support given by friends and relatives, institutional decisions or pressure, age related expectations, housing arrangements and personal living environment); (4) financial dimensions (money matters, cost factors, ability to pay for services); (5) environmental dimension (global events affecting the total population, such as war, changes in weather, deterioration of the environment).

Using a dialectical analysis of Life Events responses, we would expect some of the dimensions to be in a state of conflict. A conflict is defined as opposition in the demands of two developmental dimensions. Three or four developmental dimensions may also be in conflict. Conflict may also occur within a developmental dimension (Sinnott & Guttman, 1978). Resolution of the above mentioned conflict is defined as solving the problem by making a decision, or arriving at an answer in some manner, in regard to the life event in question. If unresolved conflict occurs on the other hand, the particular person in question is left fluctuating between the two (or more) oppositional dimensional demands.

Synthesis can be defined as the composition of oppositional parts

into a more complex whole, such as the organization of species into genera. Synthesis is not merely the choice of one oppositional demand over the other(s) (Riegel, 1977 a), but the dialectical combination of thesis and antithesis into a higher stage of truth. Applying this type of analysis to the present study, the author believes it is possible to theoretically view one's adjustment to an aged home in terms of a dialectical model. The decision to go into the home in the first place marks the beginnings of the thesis. Because of previous life events and the interaction of biological, psychological, socio-economic, social and environmental factors, the aged person in question experiences some disequilibrium. This disequilibrium produces the reason for admission to a residential setting. Once the newcomer enters his/her last home, there is a strong reaction, often making pre-admission symptoms even worse. This adjustment reaction characterizes the antithesis. The synthesis, on the other hand, corresponds to the acceptance of one's predicament (in the new environment) so that a process of adjustment can begin.

Admission to an aged home places many demands on the individual some of which the newcomer finds particularly difficult to meet. The inability to negotiate developmental demands posed by entering an aged institution (be they biological, psychological or socio-cultural), places the new resident into a state of immense conflict. Growth occurs when conflicts are resolved by synthesis. Therefore to all intents and purposes one's adjustment to an aged home can be seen in terms of one's ability to resolve these specific demands, which ultimately pre-supposes that the newcomer makes certain decisions about his/her future development. Unless one makes a series of adaptations in the biological, psychological and socio-cultural arenas, one's stay in an aged home is bound to be plagued with increasing levels of conflict, which in the final analysis, produces

maladjustment.

One of the questions that this thesis aims to answer is; does treatment help to minimise the adjustment reaction experienced by newcomers so that a more meaningful long term adjustment can be made at three months post admission? Considering that human beings require nurturance as well as health care, intimacy as well as privacy, interaction as well as isolation, emotional support as well as physical rehabilitation, and that these requisites are more critical to individuals as they become less sufficient and independent, the essential question is - can these be found in old age residences? Are newcomers able to make the necessary long-term adjustments so as to derive maximum benefits from these environments?

Research is the only way that we can attempt to answer this question. Using this approach to theoretically analyse adjustment, it is hoped to broaden the construct thereby facilitating a shift from descriptive to explanatory processes. It is the author's intention to view adjustment in terms of biological, psychological and social dimensions ...

As the dialectical paradigm traces the interactions between individual and historical development to their inner-biological and outer-physical foundations, man retains much higher and humane roles than those of an untamed beast, an empty wax plate, a playful child, or good barbarian. Through his ceaseless efforts to change nature, the changing nature changes man (ibid p.72).

In summary, it seems evident that many variables influence one's adjustment to an aged home. Factors such as physical and mental health, personality variables, socio-economic criteria, the type of facility, presence or absence of preparation and degree of environmental change

generated by the relocation, all appear to influence outcome.

There is a definite need for further studies to be carried out in order to ascertain which variables are crucial to the adjustment process. The present study was designed for the purpose of assessing the effects of two types of therapy on the adjustment of elderly new-comers to residential settings for the aged in the Western Cape.

CHAPTER 5

Hypotheses.

1. There is no statistical significant difference between the social variates of the three groups prior to commencement of treatment.

2. There is no statistical significant difference between the character profiles of the three groups.

3(a) There will be no statistical significant biological changes between the three groups at each level of assessment.

(b) There will be no statistical significant biological changes between the control group and the treatment groups at each level of assessment.

(c) There will be no statistical significant biological changes between any two groups at each level of assessment.

(d) There will be no statistical significant biological changes within any group at each level of assessment.

4(a) There will be no statistical significant social changes between the three groups at each level of assessment.

(b) There will be no statistical significant social changes between the control group and the treatment groups at each level of assessment.

(c) There will be no statistical significant social changes between any two groups at each level of assessment.

(d) There will be no statistical significant social changes within any group at each level of assessment.

5(a) There will be no statistical significant psychological changes between the three groups at each level of assessment.

(b) There will be no statistical significant psychological changes

between the control group and the treatment groups at each level of assessment.

(c) There will be no statistical significant psychological changes between any two groups at each level of assessment.

(d) There will be no statistical significant psychological changes within any group at each level of assessment.

CHAPTER 6

'Come my friends,
Tis not too late to seek a newer world.'
Tennyson.



Method.

6.1 Subjects :

A total of 90 subjects, White, English and Afrikaans speaking individuals ranging from 64-98 years in age who were admitted to nine residential aged homes in the Greater Cape Town area were asked to serve as subjects. Only five people of all those asked refused to take part in the study.

Prior to admission to the specific homes in question, these individuals lived in their own homes or apartments or with relatives. None of the subjects were diagnosed as terminal nor did they have a psychiatric diagnosis. Their physical disabilities included a range of problems from arthritis, diabetes, minor strokes, pulmonary emphysema, cardiac disorders, and urological problems.

Subjects were admitted to the homes for a variety of reasons. Personal deteriorative changes in the older person, the inability or

unwillingness of responsible others to offer the care that they, or the respondent, perceive to be required, and the inability of the current system of services to assure independent living were a few examples underlying the cause for admission to an aged home.

Newcomers to the homes were referred by their general practitioners, social welfare agencies, religious organizations, family and friends. There were also a number of self-referrals.

73 of the subjects were female and 17 were male. The preponderance of female admissions is very similar to other reported studies, for example, Kidd (1962), Mezey et al (1969).

6.1.2. Criteria for Subject Selection

(1) Subjects had to be aged 60 years and over. This age limit was decided on arbitrarily, especially since many aged homes admit patients at sixty years and over.

(2) Subjects had to be coherent, aware of the surroundings, and capable of interacting with their environment. The determination of the subjects' qualification for this criteria was assessed by their responses to the Mental Status Questionnaire. If subjects were unable to attain a minimum score of 4 points, they were excluded from participation in this study.

(3) They had to have at least partial mobility.

(4) Patients receiving psychiatric medication, namely minor tranquillizers or tri-cyclic anti-depressants were also excluded.

(5) Subjects were required to respond to interviewing in the medium of English, even though many were bilingual. The reason for this is test standardization.

(6) This had to be the newcomer's first admission to an aged home.

6.2 Aged Institutions Used :

The administrators of 15 homes for the aged in the Western Cape were approached. Of these, 9 gave their permission for full participation in the study. These homes represent a cross-section of the various residential facilities available in Cape Town and include sub-economic, economic, and private categories. The majority of homes come under the auspices of the Cape Peninsula Welfare Organization for the Aged who supervise homes for all the various religious denominations. It should be noted that purely Afrikaans-speaking homes were excluded since psychological examination of subjects could only take place in English. Many of the homes chosen do have Afrikaans-speaking individuals within them and, in general, most homes do not exclude people on the basis of language criteria. But to participate in this study, residents had to be conversant in the medium of English. The various homes were scattered throughout the greater Cape Town area. Most of these homes ordinarily exclude the overtly mentally ill, the severely mentally impaired, and the acutely or notably physically ill.

For a discussion on the type of homes encountered in this study, see (Appendix I).

6.3 Treatment Groups :

Subjects in two of the three groups employed in this design received treatment commencing immediately after the initial psychometric assessment had been completed. The treatment lasted for five weeks and was carried out by two social workers, one per group. Subjects assigned to experimental Group A received Crisis Therapy whereas those

assigned to experimental Group B received the benefits of a Social Attachment and Activity Program. In the section that follows, we shall outline the specific techniques and strategies employed within each treatment group.

6.3.1. Group A : Crisis Therapy

The following is a working model of the treatment for the crisis situation that the newcomer experiences when entering an aged residential facility in what appears to be his/her last home. It is based on the work of Golan (1978) and Burnside (1970).

Crisis intervention does not lend itself to neat marking-off into the study, diagnosis, treatment planning, treatment, and termination/evaluation steps of the casework process. Instead we speak simply of beginning, middle, and ending phases.

(a) The beginning phase - formulation : This involves establishing contact, finding out what is going on, determining whether a crisis exists and what its current status is, and setting up a contract for future activity. The formulation is usually completed in the first interview which lasts approximately 1½ hours. For the step-by-step procedure to be applied at this stage which has been outlined by Golan (1978), see (Appendix 2).

(b) The middle phase : This stage concentrates on implementation : the identifying and carrying out of tasks (by the client, the workers, and/or significant others) designed to solve specific problems in the current life situation, to modify previous inadequate or inappropriate ways of functioning, and to learn new coping patterns. Treatment is geared to achievement of limited goals already specifically decided upon as implied by the nature of the contract.

Elements in the total crisis predicament are reviewed and reworked, including affective ties (where appropriate) to previous unresolved conflicts and similar crises in the past. Emphasis in the latter situation is on recognition of recurrent patterns of feeling, thinking, and behaving on the linkages, similarities, and differences between the past and the present, and on the severing of inappropriate connections so that the person may feel once more in control of his life and free to respond to the present reality. Specific aspects of the current situation are the primary focus, and the immediate aim is to help the panicked, pressured client regain his sense of ego autonomy (Golan, 1978, p.82).

For a more detailed account of the specific techniques employed see (Appendix 2).

Similarly, Burnside (1970) argues that in this stage of the proceedings, the therapist must clarify what he does not understand ...

Intervene in the confusion. I have found that in these stress situations patients get confused about date and time, so I make a special point of telling them what day it is, what month, what time of day, etc.

Consistently test reality. State how you see the present predicament, and how you feel about it.

Offer understanding, but do not give false reassurance. Do not give the impression that all is hopeless. Not much hope is left for many of them, and it is too easy to assume their attitude instead of maintaining one's own viewpoint.

Explain what your limits are, exactly what you can or cannot do. Patients often wanted me to call relatives to come and get them,

or for me to push them out the door, or take them somewhere else, etc.

Use Lindeman's principles to assist them with grief work :

'Emancipation from the bondage of the deceased.

Readjustment to the new environment.

New relationships'

To accomplish above goals, offer catharsis, support, and sympathy

(p.19).

(c) Termination : The ending phase involves reviewing the intervention from the start of the case to the present, with emphasis on the tasks accomplished and the coping patterns developed or the building of new ties with persons and resources, and the planning for the near future when the client will be on his own.

All in all, the entire Crisis Therapy program was applied to each selected resident for five weeks. The first session lasted the longest, (up to 2 hours), and thereafter the remaining nine sessions were approximately an hour each. Throughout the duration of treatment the therapist's stance was active, purposive and committed.

This therapeutic approach which has been outlined above followed the prescriptive determinants of Crisis Theory and was specifically geared to aiding individuals who present in a state of active crisis. The reader is reminded that one of the fundamental assumptions upon which this thesis stands is that entrance to an aged residential facility by a newcomer marks the beginnings of an active state of crisis. As we have pointed out in the rationale for this particular study, people in such a frame of mind are most likely to benefit from Crisis Therapy.

6.3.2. Group B : Social Attachment and Activity Program.

The following is a description of the content and procedure that was carried out for members who were selected to this group. Each specific newcomer was told that the therapist was a volunteer from the community and would be spending five one-hour sessions discussing the residents' interests, pleasures and hobbies.

The first session was an introductory one, aimed at bonding with the new resident. The worker took a detailed history of, as well as rank ordered, the person's interests and hobbies. For an account of topics covered see (Appendix 3). The interpersonal relationship between therapist and newcomer was as much a priority as was the documenting of specific interests. The social worker attempted to find out about the person "as a person" (e.g. where he was from, information about his family, his previous occupation, where he was living prior to coming to the aged home, etc., etc.). Likewise she, using Jourad's technique of self-disclosure shared some personal details about her family, interests, and social activities. By adopting this framework it was hoped to develop open communication and an atmosphere of care and support. Prior to terminating the first interview a contract was established wherein the worker informed the new resident of the duration of the entire program and when the next session would take place.

The next stage of the procedure was for the worker to go and do research on the newcomer's particular interests and hobbies, so as to be fully conversant in all areas outlined. Examples included : Eighteenth-century German architecture, basket weaving, sculpturing, pottery, South African test match cricket, classical music, etc., etc. A theme for each meeting was prepared prior to the session.

During these sessions it was the worker's explicit intention to motivate the resident to actively participate in discussing the various topics. She did this by taking a 'student-like role' in which questions were asked of the so called expert, thereby facilitating a process by which the resident demonstrated mastery of his/her subject. By so doing, the aged newcomer felt in control and retained a sense of dignity which was contrary to the helplessness experienced by being institutionalized. Throughout the entire five week program, the worker was supportive and encouraged assertiveness and the use of the resident's initiative. When these attributes were demonstrated by the resident, praise and admiration was freely given.

On occasion where residents complained of problems they had encountered in the home or with their relatives, the worker listened sympathetically but in no way engaged in therapy or advice giving. If demands for problem-solving became apparent, the worker would de-focus these and subtly reintroduce the activity at hand.

The objective of this program was a rehabilitative one. In today's rapidly changing world, people tend not to listen to "the way it was" or to see the value of "how it used to be". By getting residents to talk actively about past and present interests in a semi-didactic fashion an attempt was made to give them the self-respect and satisfaction that comes from being needed and serving others. Margaret Mead reminds us that the aged know something that youth need to know.

The rationale of employing this approach is that self-produced feedback is necessary for attachment. The individual initiates action that leads to some form of sensory, affective, or cognitive stimulus from the attachment object (social worker) thus giving the initiator of the action a sense of mastery, control, or power. This therefore reduces the feelings of vulnerability and helplessness which are so characteristic

of the institutionalizing process. Once this has been achieved, creativity, generativity and risk-taking occur, thus enabling ever new and broader attempts to explore the social environment which, in turn, increase the sources of predictable feedback and outcomes. Using this technique, it was hoped to re-enhance socialization so that the newcomer could make the necessary adjustments to a new and sometimes frightening environment.

6.3.3. Group C : Control :

The members of the C group were given no treatment following their entrance to the aged home.

6.4. Therapists :

The literature is replete with examples which suggest that therapist variables are as crucial to the evaluation of outcome as is any specific treatment employed (Fiske et al, 1970; Strupp, 1973; Gurman and Razin, 1977).

Considering methodological issues in research of the psychotherapist, Fiske (1977) outlines important therapist variables :

- (1) general characteristics, for example : sex, age, ethnic group.
- (2) psychological attributes assessed outside the treatment room, for example : personality variables, aptitudes, interests.
- (3) professional biographic variables, for example : profession, training experience.
- (4) views about psychotherapy, for example : theoretical orientation, beliefs about mental health and psychotherapy, expectations about patients and outcomes.

- (5) variables specific to each patient, for example : therapist's perceptions of the patient, his assessments of the patient's personality, and his expectations about potentiality for gain.
- (6) characteristics of the therapist's behaviour during a treatment for, for example : variables summarizing the patient's verbal or non-verbal behaviour per hour or per total course of treatment.
- (7) contextual variables, for example : therapist's responses to particular acts or statements of the patient (p.29).

Attempting to control for as many of these variables as is possible, two Jewish female social workers of approximately the same age and both postgraduate students from the University of Cape Town served as therapists. Each worker completed the Cattell 16PF Inventory so as to investigate their respective personality profiles (see Appendix 5). No significant differences were found between their profiles.

The therapists were given specialized training in the following areas :

- (1) Facts about the elderly : This included facts concerning the physical and mental aspects of aging. In addition, information relevant to the stresses frequently encountered by the aged (e.g. role loss, loss of power, loss of loved ones, and financial insecurity) were emphasised.
- (2) Listening : A workshop dealing with both the verbal and non-verbal aspects of communication in the aged was conducted.
- (3) Treatments : Crisis Therapy and the Social Attachment and Activity Program (see Appendix 2 and 3) were explained in detail. The crisis intervenor attended a specific Crisis Therapy Workshop prior to beginning the study so that she could be fully equipped to carry out the required treatment proposed by model. Practice sessions were conducted to help

familiarise the therapists with the procedures. Role playing was used extensively to acquaint the therapists with the treatments and to assist them in coping with problems that might arise. In addition, trial treatments were practiced on two elderly residents who were admitted to an aged home.

(4) Orientation period : Both workers were required to visit each home and familiarise themselves with the staff and dynamics of how the home was run. They were informed about the rules and regulations of each home and became acquainted with the services offered by each environment.

6.4.1. Psychometrician :

The author, a registered clinical psychologist with prior experience in the psychological assessment of geriatric patients, served as the test administrator for the entire sample.

Prior to formal testing, inter-rater reliability studies were carried out on the tests that required them (see Apparatus).

The tester had no prior knowledge of the subject's membership in either the treatment or control groups.

Apparatus.

Most previous studies in this field have failed to focus upon the developmental interdependence of the individual and society and have rather set their goals on investigating quantitative data. Following the dialectical orientation of Riegel and Wozniak (1975), this study looks at dialectical interactions between the changing individual and the changing world. It not only considers the aged person on a psychological basis, but looks equally at biological and socio-cultural criteria. By so doing, it places him in the context of a real-life situation. The developmental process of aging in relation to the need for institutionalization is studied against a backdrop of physical and mental health, socio-economic criteria, family relationships, as well as community involvement. To all intents and purposes, the individual is perceived as a multi-facet organism, in a state of dynamic tension.

The three groups were compared on the following parameters :

- (a) biological/physical.
- (b) psychological/psychiatric.
- (c) Socio-economic/social.

Assessments took place on admission, at 6 weeks post-admission, and a follow-up was conducted at 3 months. All tests were repeated each time except for the personality inventory, which was only used on admission.

6.5.1. BIOLOGICAL/PHYSICAL VARIATES (3 SCALES).

These parameters were assessed by the following instruments :

- (1) Lefevre Morbidity Scale : Physical morbidity is an extremely

difficult concept to measure. It may best be perceived on a continuum of which asymptomatic disease and terminal illness are polar opposites. Interspersed between these polarities are (a) illness of which the person is aware but which does not affect his behaviour, e.g., mild intestinal upset, and (b) illnesses which cause the person to seek medical attention, perhaps including hospitalization. In this case there may be varying degrees of interference with usual activities.

Morbidity is far less definite than mortality and represents a dynamic rather than a static phenomenon. International commissions have suggested to research workers that rather than attempting to sample for specific illnesses in the aged population, it is more meaningful to assess the physical symptoms of distress or discomfort which impair a healthy level of functioning.

Following international trends, Dr. K. Lefevre (1977) (Department of Psychiatry, University of Cape Town) developed a scale which offers a profile of physical morbidity drawn from the following variables, each measured on a 4-point scale: Pain, Dyspnea, Vision, Hearing, Stiffness/Weakness, and Incontinence. (Scores of 0 = none, 1 = mild, 2 = moderate, and 3 = severe). Rather than attempting to assess each type of specific illness in the aged population under investigation, he focused primarily on a simple global measure of impairment of physical functioning.

The questions asked in this instrument are directed at the patient's subjective experience and more particularly the social effects of the patient's impairment as experienced by him/her. These measures reflect a subjective feeling or manifest symptoms of sickness and do not purport to measure an enumeration of underlying pathological changes.

On the basis of the above-mentioned rationale, the present author regards this instrument as being particularly suitable for use in this study. It has been standardized on a geriatric population and the compilation

of this scale meets with the reliability and validity criteria of other research instruments used to measure the same concept (see Appendix 1 A).

(2) The Physical Self-Maintenance Scale :

Older people in institutions suffer from many physical disabilities. Most of these ailments are chronic in nature. The salient fact about these multiple chronic health problems in relation to reasons for institutional care is that they result in functional disability. In other words, the ailments impair the individual's capacity to care for himself in normal living situations. The most commonly noted disabilities are in the spheres of ambulation and self-care.

This measure assesses the individual's ability to care for self in regard to toileting, feeding, dressing, grooming, physical ambulation and bathing. Each scale, A through to F, is checked to indicate the patient's status regarding each function. His/Her score may range from 0 - 6, one point being given for each function in which the subject obtains the most independent score. Thus the score communicates the general level of his/her self-maintaining capacity. (Low scores indicate the patient's incapacity to look after himself/herself). The specifics of his/her abilities and disabilities are conveyed by reference to the point on each scale where his/her competence lies (see Appendix 1 B).

Lawton and Brody (1969) have found after assessing 343 cases, applicants to a home for the aged had a mean score of 4,1; patients admitted to a mental hospital reception centre had a mean score of 3,5; and protective custody patients had a mean score of 2,0.

(3) The Physical Scales of the PAMIE :

A review of the literature reveals methodologically sophisticated

instruments for quantifying the behavioural and symptomatic manifestations of mental disorders. However, little of this instrumentation is directly applicable to broader populations of the aging and non-psychiatric chronically ill. Approaches which have attempted to rate disability include some combination of self-care activities : feeding, bathing, dressing, toileting/continence, and locomotion.

Perhaps a more comprehensive and methodologically advanced effort to date is the Stockturn Geriatric Rating Scale (Meer and Barker, 1966). It is to this kind of instrument that the Physical and Mental Impairment of Function Evaluation is most closely related - (PAMIE) One of the most important intentions in drawing up this scale was to reflect the psycho-biological unity of behaviour in the chronically ill. In light of the multiple pathology and complex interplay of psyche and soma in the aged, it was the researcher's intention that this scale should adequately reflect the essential unity and organismic integrity of the individual. Further, it was the explicit aim of this measure to provide a multi-functional assessment of physical, psychological and social/interpersonal disabilities.

Here only the relevant four factors were used : three first order factors (self-care dependence, bedfast/moribundness, and sensory motor impairment) and a second order factor (physical infirmness).

Interval consistency (Cronbach Alpha) coefficients and inter-correlations of the factor scores indicate that the PAMIE factors are sufficiently reliable for further use and exploration (see Appendix 1 C).

Information to answer these questions came from reports by the nursing staff and/or medical notes.

6.5.2 PSYCHOLOGICAL/PSYCHIATRIC IMPAIRMENT :

Data gathering in this section was divided into the following general

sub-categories :

- (1) Psychiatric Impairment.
- (2) Cognitive Functioning.
- (3) Emotional State.
- (4) Affective Responsiveness.
- (5) Self Perception.
- (6) Social and Interpersonal Involvement.
- (7) Personality Factors.

(1) Psychiatric Impairment (2 scales) namely :

(a) The Brief Psychiatric Rating Scale :

This scale was developed by Overall and Gorham (1962) and comprises 18 symptom constructs which are rated on a seven-point scale of severity which range from "not present" to "extremely severe" (see Appendix 1 D). This scale was developed to provide a highly efficient, rapid assessment technique to evaluate change in psychiatric patients during their course of treatment in a hospital. Furthermore, it is a scale which provides a comprehensive description of the major symptom characteristics that a psychiatric patient is likely to present with. In other words, it is a means of assessing his/her mental state.

The authors recommend an interview duration of eighteen minutes and provide a schedule to assist the interviewer in making his assessment. The eighteen minute interview is divided up into a three-minute interval in which the interviewer establishes rapport with the patient and a ten-minute period of non-directive interaction and, finally, a five-minute period of direct questioning. The authors

indicate that this schedule should not be regarded as inflexible and can be modified wherever necessary.

The Brief Psychiatric Rating Scale has been reported in the literature to be a reliable and valid instrument (Freedman, Kaplan & Scott, 1975, Vol.2). However, there is much evidence to suggest that psychiatric ratings as applied to ordinary clinical use are notoriously unreliable. It was therefore important to establish inter-rater reliability of the schedule ratings made. A special reliability study was completed before formal testing began in which both interviewer and observer and following day repeat interviews were undertaken. The product moment correlation coefficient between interviewer and observer for the total number of positive ratings was 0.87 and for re-interview comparison 0.78. This was considered good in comparison with other studies of diagnostic reliability.

On the basis of these findings the author selected this test as a measure of the residents mental state during their first three months in an aged institution. Furthermore, it was particularly useful in determining psychological changes that occurred within this period. Another valid reason for using this scale is that it had been used in a previous study with geriatric patients for similar purposes. Stotsky (1967) used this as a measure in a study of "Successful Adjustment of Mental Patients to Nursing Homes

(b) Mental Scales of the PAMIE :

The following first order factors have been used to denote psychological impairment of functioning : (a) belligerent/irritable (b) mentally disorganized, (c) anxious/depressed, (d) behaviourally deteriorated, (e) paranoid/suspicious, (f) withdrawn/apathetic.

were selected because they correlated highly with the Pascal (1951) score on a sample comparable to that of the present study (Lieberman, 1965). The adequacy of the aged subject's reproduction was interpreted as a measure of ego organization-disorganization.

The administration of the test is simple. The subject is presented with each of three designs in succession and asked to draw them exactly as he/she sees them, all designs being drawn on a single sheet of paper. The subject is given no help by the interviewer even in cases of extreme sight difficulty. The subject is not permitted to erase.

The designs as produced by the subject are assigned a score if they exhibit any deviations from the original designs designated on the scoring sheet; this is explained more fully in the appendix (Appendix 1 F). No score is given unless a deviation is present; thus a low score indicates relatively faithful reproductions of the designs and a high score indicates considerable discrepancy between the original designs and the subject's reproduction of them.

Poor scores are associated with psychiatric disability, organic brain damage, less adequate reactions to physical stress and the inability to cope with cognitive complexities of the physical environment (Bender, 1938; Billingslea, 1948; Pascal & Suttell, 1951). Decreased levels of inner organization as measured by adequacy of the Bender-Gestalt reproductions are also associated with imminent death (Lieberman, 1965). Before actual testing commenced, a reliability of 92% agreement was established using protocols in (Pascal and Suttell, 1951).

(17) fatigability; (18) loss of appetite; (19) weight loss;
(20) somatic pre-occupation, and (21) loss of libido (see Appendix 1 G).

Generally, the inventory is administered by a trained interviewer who reads aloud each statement in the category and asks the subject to select the statement that seems to describe him best at the moment. The subject also has a copy of the scale so that he can read each statement to himself as it is read aloud.

On the basis of the subject's response, a number is circled next to the appropriate statement. The total score is obtained by adding the scores on the symptom categories. Scores of 0-4 suggest no depression; 4-7 mild depression; 8-16 moderate depression and over 16 severe depression.

Beck (1972) employed two methods of evaluating the internal consistency of the inventory. Protocols of 200 patients were analysed and the scores for each of the 21 items were compared with the total score on the B.D.I. for each patient. Each category evidenced a significant relationship to the total score for the inventory. A subsequent item analysis of 606 cases showed that each item also had a significant positive correlation with the total B.D.I. score.

Split half reliability yielded a reliability coefficient of 0.86. Concurrent validity has been demonstrated by determining how well the test scores correlate with other measures of depression. Beck et al (1961) report a correlation of 0.65 with other measures of depression. On the basis of these criteria, this instrument was judged to be satisfactory for use in our study.

(b) The Life Satisfaction Index :

Neugarten, Havighurst and Tobin (1961) in connection with the

Kansas City Study of Adult Life, assembled a set of questions that seemed central for adjustment to living during old age. Using information obtained from depth psychological interviews as validating criterion they painstakingly devised two measures of adjustment : (1) Life Satisfaction Index A, and (2) Life Satisfaction Index B. The former scale has been analysed further and its length reduced to 13 items.

Among the normal aged, Wood, Wylie and Sheaffer (1969) found that 0-12 indicated low morale, 13-21 moderate, and 22-26 high morale. Adams (1969) has analysed the response of the L.S.I.-A. items to determine the reliability of index items and has in accordance with Wood et al's (1969) findings, rejected two items. In addition, Adams (1969) has by means of factor rotation indicated that only four factors are measured by the index. He has suggested that the component self concept is inherent in the respondent's answer to all the items and is thus represented by implication in all the factors.

The actual questionnaire used in this study (see Appendix 1 H) has the following validity and reliability coefficients .57 and .79 respectively.

4. Affective Responsiveness (2 scales) :

The stories told to five of the Murray Thematic Apperception Test (TAT) were analysed to assess affective responsivity. Two measures were developed, namely : (a) range of affects,

(b) willingness to introspect.

The five cards were :

CARD 1 : - A young boy contemplating a violin resting on a table

CARD 2 : - A family farm scene with a younger woman in the forefront looking off in the distance and an older woman in the background.

CARD 6BM : - A short elderly woman standing with her back to a tall young man, who is looking downward with a perplexed expression.

CARD 7BM : - A younger and an old man facing each other, only their heads, which are fairly close together, are shown.

CARD 17BM : - A naked man in the position of climbing up or down a rope.

(a) Affective Range ;

Affect displayed in stories told to the Murray TAT cards was used to assess affective responsiveness. The score was made up of the number of different affects of a possible total of seven, that were introduced in stories told to the five Murray TAT cards.

(b) Willingness to Introspect :

Gendlin and Tomlinson's (1967) measure of the ability to experience was used to measure willingness to introspect. This scale is structured so as to discriminate seven levels for the introspective exploration of feelings. High scores apply to self-reports that include direct reference to intense feelings and introduce diverse introspective strands to further self-understanding. Scores at the low end of the scale apply to verbalizations that indicate that feelings are being ignored or described in an impersonal, unfocused fashion.

The manual and questionnaire consist of a series of instructions requiring the respondent to focus in silence on inner feelings and

then to evaluate the experience. For example, the respondent was asked, "Can you tell me about the times when you feel lonely?" If none was mentioned, the interviewer was encouraged to say, "How often? How do you feel? What do you do so as not to feel lonely?"

In a pilot test, scores of loneliness correlated highly with the total score on all eight affects ($r = .75$).

5. Self Perception (2 scales) :

The self concept is defined as the attitudes of the individual toward himself, the way in which an individual views himself.

Two measures of self concept were used in this study :

(a) The Lieberman Rosner Self-sort Task is based on Leary's (1957) interpersonal factors of personality. Those conscious or unconscious processes which people use to deal with others and to assess others and themselves in relation to others (PV). Series of statements which describe the person as he is now, using Leary's eight octant interpersonal themes are : managerial-autocratic (AP); competitive-narcissistic (BC); aggressive-sadistic (DE); rebellious-distrustful (FG); self-effacing-masochistic (HI); docile-dependent (JK); cooperative-over conventional (LM); and responsible-hypernormal (NO).

Each category has a moderate (adaptive) and an extreme (pathological) intensity, e.g., managerial-autocratic. The Self-sort Task consists of 48 cards, three for each theme, graded in intensity from 1 low to 3 high. For example, for the managerial theme :

I enjoy being in charge of things	= 1
I am a good leader	= 2
I am somewhat of a dominating or bossy person	= 3

For the autocratic theme :

People think well of me = 1

I believe that I am an important person = 2

I frequently give advice to others = 3

(see Appendix 1 I)

The subject is presented with a deck of 48 cards containing self-descriptive statements and is asked to select from the deck those cards which he feels describe himself as he is now. The number of each card selected is recorded.

Scoring : Raw Score = number of items chosen (maximum 48)

Weighted total of items chosen = number of items of highest intensity x 3
number of items of middle intensity x 2
number of items of lowest intensity x 1

Intensity Score = $\frac{\text{weighted score}}{\text{raw score}}$

Octant Score = $\frac{\text{number of statements chosen in an octant}}{\text{Total number of statements chosen}}$

Pattern of scores on the octants were converted into two numerical indices locating S's interpersonal behaviour in a two-dimensional space, Love and Dominance. Leary's formulas (1957) for the global Love and Dominance scores.

Love : $LM - DE + .7 (NO - BC - FG + JK)$

DOM : $AP - HI + .7 (NO + BC - FG - JK)$

Simply stated, the dominance submission dimension is the difference between proportions of managerial-autocratic behaviours, and self-effacing-masochistic behaviours, whereas affiliation-hostility is the difference between proportions of cooperative-over conventional behaviour and aggressive-sadistic behaviour.

Research by Rosner (1968) has indicated that there is a stability of item selection by respondents upon retesting. A pilot study was initiated by the present author in which a group of twenty respondents were tested on the Self-sort Interview task for the first 6 weeks after their entrance into the homes. Stability of items from week to week remained as high for these twenty respondents as for any other group studies, despite the immediacy of the disruptive life change. Measures related to the self-subsystem showed the highest stability coefficients (generally in .50's).

(b) The Osgood Self Evaluation Scale (1957) is presented by saying, "I have some words which describe how people think of themselves. I'd like you to make a choice." For example, "Do you think of yourself as being" (present sheet) "Very Happy, Quite Happy, Happy, Neither Happy nor Sad, Sad, or Very Sad"

Have subject make choice. Repeat instructions if necessary. Interviewer will mark choice made. Each Osgood dimension is presented to the subject on a separate sheet of paper.

Each of the five Osgood dimensions (see Appendix 1 J) are scored on a 1-7 scale (where F represents the most positive end). By adding the Scales, obtain range of 5-35, with high scores being positive self-evaluation.

6. Social and Interpersonal Involvement (3 scales) namely :

(a) Bell's Social Involvement Scale :

Interpersonal level of functioning or Social Involvement was measured by means of a Social Involvement Scale (Bell, 1967), modified to include all available activities offered at the particular institution.

The list consisted of a series of questions designed to assess "formal social involvement" (attending clubs, associations, etc.); "family social involvement" and "informal social involvement", (playing cards).

The instrument is comprised of a list of 13 activities rated on a scale from 0-26 according to the frequency of activity, (e.g. once a day, once a month). Each item was scored on a calculated proportional basis relative to the frequency of events which were maximally possible (for example, playing cards once a day was given the same rating as attending the friendship club twice a month as both represented the maximum frequency of activity possible).

The validity of the list was checked by the social worker and/or matron of each home to ascertain that the list was an adequate representation of available social interactions (see Appendix 1 K).

(b) Assessment of Interpersonal Behaviour :

The resident's interpersonal qualities were assessed during the interview. Five areas were assessed : (a) depth (b) warmth (c) motivation (d) cooperation, and (e) spontaneity. Each construct was rated on a five-point scale, with 1 being low and 5 being high (see Appendix 1 L).

Prior to formal testing an inter-rater reliability measure was established. Two types of analyses were undertaken to assure that a systematic bias did not exist. Ten waiting list interviews done by three interviewers were compared for style of respondent/interviewer interaction. Each interviewer also completed an extensive questionnaire related to their reasons for working on the study and their attitudes towards respondents. These analyses revealed remarkable

consistency among interviewers supporting a high comparability of data across interviews.

(c) Subjective Rating of Social Adjustment :

Residents were asked to rate their own level of social adjustment to their new environment. It was the author's intention to leave this assessment as open-ended as possible, allowing the resident's own understanding of what constitutes adequate social adjustment to determine the response made. If he/she could not give their own response to this ten-point scale, they were prompted with the following questions :

- (1) To what extent do you accept and realistically enjoy other people in the home?
- (2) To what extent do you participate in small group activity in the home?
- (3) To what extent do you accept others as they are?

After allowing residents to embroider each point, they were then asked to rate their subjective feeling of social adjustment.

7. Personality Factors (1 scale) :

The Cattell 16PF (1962)

The Cattell (1962) 16 Personality Factor Test (Form C) was selected as the instrument to measure personality traits. This is a test based on factor analytic techniques and it was selected for use in this study on the basis of the following criteria :

- (1) a reduced vocabulary level.
- (2) sensitivity to a wide range of personality variables.
- (3) sufficient brevity to reduce fatigue effects which may occur in an aged population; and
- (4) the extensive use of the Cattell Personality Test (Cattell & Stice, 1954; Davol, 1958; Karson, 1959) with test-retest reliabilities reported (Cattell, 1956).

Thirteen Cattell Factors are included in the personality measure :

- FACTOR A : Aloof (Schizothymia) vs. Outgoing (Cyclothymia).
- FACTOR C : Emotional (General Instability) vs. Mature (Ego Strength).
- FACTOR E : Submissive (Submission) vs. Dominant (Dominance).
- FACTOR H : Timid (withdrawn Schizothymia) vs. Adventurous (Adventurous Cyclothymia).
- FACTOR L : Trustful (Lack of Paranoid Tendency) vs. Suspecting (Paranoid Tendency).
- FACTOR M : Conventional (Practical Concernedness) vs. Eccentric (Bohemian Unconcern).
- FACTOR N : Simple (Naive Simplicity) vs. Sophisticated (Sophistication).
- FACTOR O : Confident (Freedom from Anxiety) vs. Insecure (Anxious Insecurity).
- FACTOR Q₁ : Conservative (Conservatism) vs. Experimenting (Radicalism).
- FACTOR Q₂ : Dependency (Group Dependency) vs. Self-Sufficient (Self-Sufficiency).
- FACTOR Q₃ : Uncontrolled (Poor Self-Sentiment) vs. Self-Controlled (High Self-Sentiment).
- FACTOR Q₄ : Stable (Relaxation) vs. Tense (Somatic Anxiety).

Each of the above personality factors are based on six items.

"Yes" or "No" response categories were used. The test was given orally with the examiner marking S's responses on an answer sheet. The scoring is on a 0-6 point scale (6 being high). (See Appendix 1 M).

Correlates of each Factor with emphasis on the high score pole are as follows :

FACTOR A : Warm, Outgoing (Cyclothymia).

Success in "dealing with people". (Kelley and Fiske, 1951). More readily from active groups; more generous in personality relationships; less afraid of criticism; proneness to manic-depressive disorders (Cattell, 1957). Evidence of substantial hereditary determination of this Factor, i.e., it is a temperamental tendency (Cattell, Blewett, and Beloff, 1955).

FACTOR C : Mature (Ego Strength).

Associated with resistance to emotional stress. High C persons do significantly better on various kinds of endurance tests (Cattell, 1957). In questionnaire, C person easily annoyed by things and people, is dissatisfied with the world situation, his family, the restrictions of life, and his own health (Cattell, 1957). In neurotics, low C pattern associated with poor muscle tone and posture, with a history of symptoms of neurotic behaviour in childhood, and with increase of neurotic symptoms when away from home or other stress (Cattell, 1957; Eysenck, 1953).

FACTOR E : Dominant (Dominance).

Less prone to practice true projection in misperception situations (Wenig, 1952, as quoted by Cattell, 1957). Associated with boldness, courage, task oriented contributions, criticism

of leaders and others (Cattell, 1957).

FACTOR G : Conscientious (Super Ego Strength)

Involves success in a variety of performances requiring persistence, freedom from oscillation, and good organization of thinking (Cattell, 1941). Associated with correctness of manners and morals, planfulness, caution, and preference for efficient people to other companions. Low in pathological syndromes (Cattell, 1957).

FACTOR H : Adventurous (Adventurous Cyclothymia).

Associated with exuberance, tendency to recall emotional rather than non-emotional material, freedom from fatigue on repeated stimulation, and other measures of a general dynamic vigour and spontaneity. Clinically high in manic depressives and low in neurotics (Cattell, 1957).

FACTOR L : Suspecting (Paranoid Tendency)

High inner tension as measured by the general anxiety factor. Anxiety, which takes the form of a feeling of social insecurity, together with compensatory behaviour and projection. Clinically showing paranoid disorder (Cattell, 1957).

FACTOR M : Eccentric (Bohemian Unconcern).

Associated with creativity, autonomy and self-absorbed relaxation; subjectivity of a strong inner life versus constant responsiveness to the environment. Disregard for rules of procedure, more accident-proneness (Cattell, 1957).

FACTOR N : Sophisticated (Sophistication).

Associated with a generalized mental alertness, health, and

efficiency; quite well matched with objective test factors showing an alertness to social success and survival, and expedient rashness in solving problems, and realistic self-criticism (Cattell, 1957).

FACTOR O : Insecure (Anxious Insecurity)

One of the largest factors in anxiety. Associated with tendency to phantasy (Wenig, 1952, as quoted by Cattell, 1957). Appears centrally in the depressive, anxiety syndrome and tends to be high in neurotics and many psychotics. Most distinguishes those who "act out" their maladjustment from those who suffer it as an internal conflict. Select few peers as friends; do not feel accepted in groups.

FACTOR Q₁: Experimenting (Radicalism)

Associated with quickness of reaction time and general judgement as well as low cardiac response. Factor same as Thurstone's Radical-Conservatism factor found in attitudes and interests (Cattell, 1957).

FACTOR Q₂ : Self-Sufficient (Self-Sufficiency).

Marked correlations with other "introvert factors; tends to be rejected in groups; solves problems for self; apparently no change with age (Cattell, 1957).

FACTOR Q₃ : Self Controlled (High Self-Sentiment)

Q₃ person shows socially approved character responses, self control, persistence, foresight, considerateness of others, conscientiousness, and "self respect" (Cattell, 1957).

FACTOR Q_4 : Tense (Somatic Anxiety).

One of the three highest factors in general anxiety.
Abnormally high in manic-depressives and in psychopathic personalities (Cattell, 1957).

According to Cattell (1957), two major second order factors have been found in the 16PF - Anxiety and Introversion. Anxiety seems to be a product of Excitability (Q_4), Insecurity (O), Constitutional Timidity (H-), poor Self-Sentiment Development (Q_3 -), Ego Weakness (C-), and Suspicion, Jealousy (L-).

The general Introversion factor includes loadings of warm/cold (A-), Enthusiasm/Glum (F-), Adventurous/Timid (H-), Eccentric/Conventional (M), and Self-Sufficient/Dependent (Q). The weighting of these two second order factors is as follows :

Anxiety Score :

High score means more anxiety and this total may range from 0-54 points.

Q_4 (+Score) x 2

O (+Score) x 2

L^+ (+Score) x 1.

C- (6-Score) x 2

Q_3 (6-Score) x 2

Introversion-Extroversion Score :

High scores mean more introversion and may range from 0-48 points.

A- (6-Score) x 2

F- (6-Score) x 2

H- (6-Score) x 2

M+ (+Score) x 1

Q₂ (+Score) x 1

The version of the 16PF used (see Appendix 1 M) is not identical with any of the three published forms of the instrument but it bears the greatest resemblance to Cattell's "Form C" which is characterised by its brevity (six items per factor) and its relatively simple vocabulary.

Using a format that has been standardized on a Geriatric Population (Prock, 1965) we felt it would reflect the most valid appraisal of personality in an aged population.

6.5.3. SOCIO-ECONOMIC/SOCIAL VARIATES (7 SCALES) :

(1) Marital Status :

- (a) Single, Divorced, Widowed.
- (b) If widowed, no. of years widowhood, (1) less than 2 years,
(2) 2-5 years, (3) 6-10 years, (4) 11-20 years, (5) 21-30 years
(6) 30 years and over.

(2) Educational Status :

This is operationally defined as the degree of education a person has attained. The range of standards are : (a) 2-5; (b) 6-7;
(c) 8-10; (d) Technical College, (e) University (see Appendix 1 N).

(3) Occupation :

This is operationally defined as a means of filling one's time, in regular employment. It includes the highest possible position the resident has held, even if not working presently. The categories range from :

- (a) Professional/Managerial : requiring University certificate, e.g., doctors, lawyers, engineers, teachers, accountants.
- (b) Technical : i.e., requiring a certain amount of professional training not at a university, e.g., commercial clerk, proof reader, bank clerk, draughtsman.
- (c) Artisan skilled - e.g., shoemaker, boiler-maker, dressmaker, ticket inspector.
- (d) Semi-skilled/Unskilled - i.e., no specific training required, e.g., housekeeper, shop assistant.
- (e) Never worked (See Appendix 1 O).

(4) Financial Status :

This is a measure of what the person earns, receives per year. Money is accrued either by salary, pension, or any other investments. The categories are :

- (a) R0 - R999
- (b) R1 000 - R1 999.
- (c) R2 000 - R2 999
- (d) R3 000 - R3 999
- (e) R4 000 - R4 999.
- (f) Over R5 000

(5) Ratings of the Attitudes of Significant Caring Person :

This was assessed on a ten-point scale, where high scores indicated a caring, supportive role, and low scores revealed non-support and a rejecting attitude.

An individual was judged to be strongly supportive when the interaction between the two people in question was seen to demonstrate values of respect, care, concern, and reassurance. Persons falling into the upper range had made every attempt to meet the needs of the aged individual with respect to health, finance, accommodation and emotional warmth. Individuals whose attitudes were judged to be mildly supportive (mid range of scale) were seen as being concerned but to a limited degree. Non-supportive caretakers were seen as rejecting, disinterested, and unconcerned.

(6) Ratings of Family Involvement :

Family involvement is defined in terms of frequency of contact, depth and intensity, as well as meaning and value that the elderly person attaches to interaction with his/her spouse, children and/or blood relatives. Once again the assessment is rated in terms of a ten-point scale, where high scores reveal deep involvement and low scores suggest non-involvement. The deeply involved group was seen to include individuals who regarded the elderly as an important part of their family. Such an attitude would therefore include regular visits (at least twice a week), taking the person on regular outings, affording deference to their aged and, if necessary, financial support. The uninvolved were seen as rejecting, disinterested, with little or no contact. To all intents and purposes they absolved any responsibility for their aged relative and placed

total care and concern on to the professionals and nursing staff in the particular institution.

(7) Community Involvement :

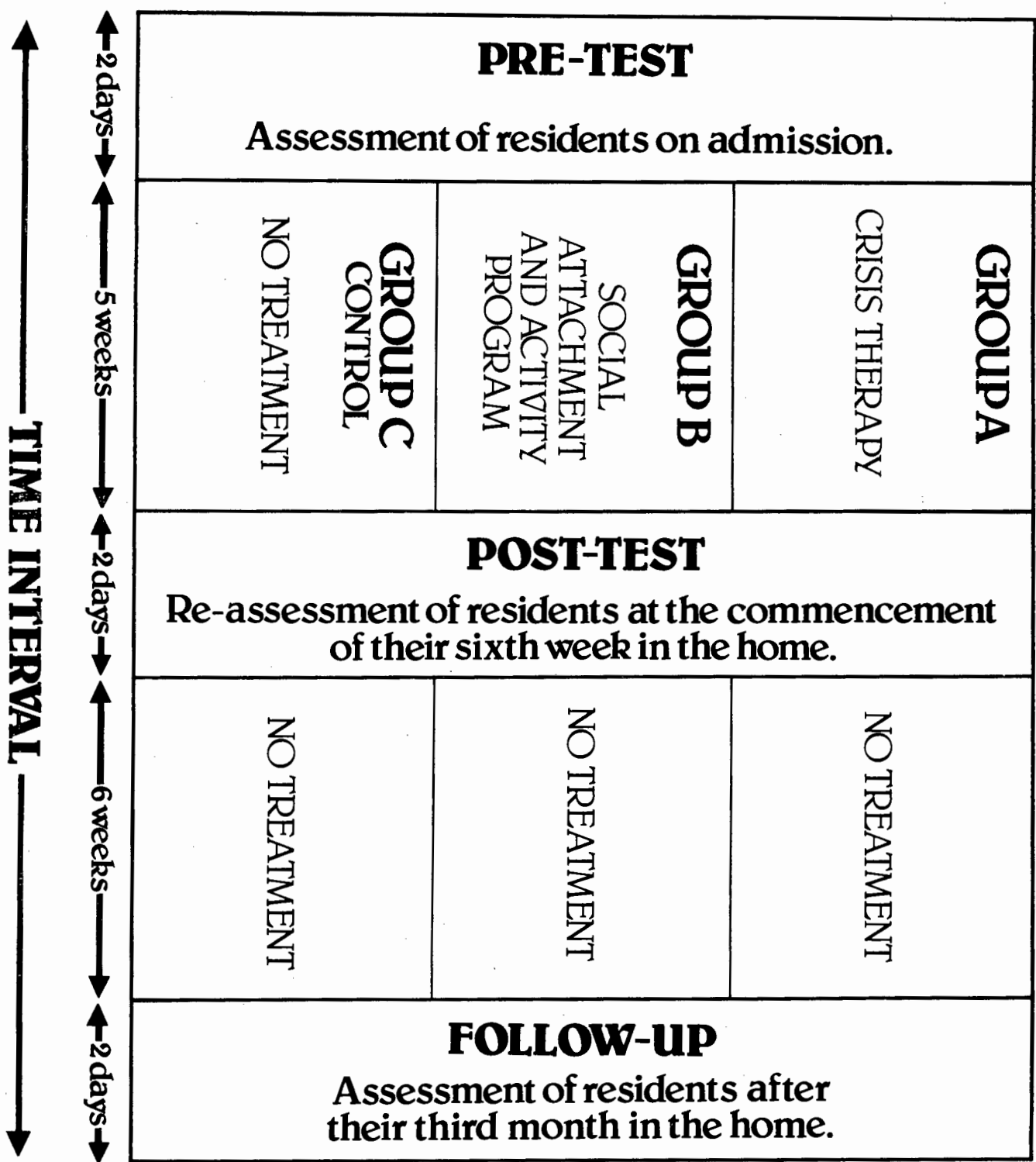
The resident's current level of continued social functioning in the community was assessed on a ten-point scale. High scores suggest social integration, whereas low scores are indicative of isolation. A well integrated person was judged to be one who could make use of social services, visit and receive visitors, do their own shopping, and generally care for themselves in a healthy fashion. Isolated individuals were seen to be withdrawn, apathetic, unable or unmotivated to make social contact, and who made no use of social services.

These complex ratings included such operations as (a) interviews with the resident (b) interviews with the relatives and significant others, (c) interviews with referring agencies and other community workers, (d) collection of information from agencies and other relevant informants, and (e) observations of repeated interactions between the resident and his/her relative and/or significant others.

Prior to commencing final testing, an inter-rater reliability for the three categories of $r = .96$ was achieved on a pilot population.

Procedure.

Experimental Design:



In an attempt to establish whether the treatment groups have been effective in minimizing the adjustment reaction experienced by aged residents upon admission to what is their last home, the design presented above was employed. It is a within subject and between group pre-test post-test follow up design which attempts to answer the hypothesis outlined previously. One of the crucial questions raised by this study inquires whether treatment A has a different effect from treatment B. It has been argued (Goldiamond and Dyrud, 1968) that aspects of therapeutic techniques can be studied over the course of treatment of each patient; comparisons of the patient's behaviour can be made between periods associated with the application of the technique and other periods. Studies of this kind are possible and may be useful in behaviour therapy. To all intents and purposes, the design used in this study draws heavily in part, on the above mentioned rationale.

The design contains three groups, two experimental groups A and B who receive treatment immediately after the initial psychometric investigation, and a control group C, who receive no treatment. The length of the treatment is 5 weeks and is determined by the rationale of Crisis Theory which states that the active crisis period experienced after any major disequilibrium approximates this interval of time. A post-test reassessment is carried out at the commencement of each person's sixth week in the home to assess the changes that have taken place after the termination of treatment. For the next six week period no group receives treatment, and then at the commencement of the resident's third month in his/her new home a follow-up assessment is carried out primarily to assess two basic issues. Firstly, to ascertain whether therapy has produced any long lasting characteristic changes in behaviour and secondly, to assess the state of the person's overall adjustment at

three months post admission. Certain studies, e.g., Turner et al (1972) have examined adaptation one year after institutionalization has taken place. Designs such as these are usually plagued by compounding methodological problems. Death, inability to complete testing due to the effects of chronic disease as well as confounding variables resulting from a change in sample homogeneity suggest that these designs are not suitable for assessing the outcome of treatment procedures over an extended period. If one wants to assess whether there are any protracted benefits from intervention a follow-up must be carried out fairly early so as to avoid the confounding issues outlined above.

The names and ages of individuals being admitted to the aged homes were obtained from the admission officer of each home. All potential subjects were randomly assigned to one of the three groups before any contact was made with them in the following fashion :

ABC, BAC, CAB

ACB, BCA, CBA

This procedure took place concurrently in each institution being used.

Step one in the procedure was to conduct an intensive psychometric investigation of all potential subjects. The test administrator was a full-time registered clinical psychologist who had no prior knowledge of the subjects' membership in either the treatment or control group. The first test administered in the psychometric battery was the Mental Status Questionnaire and if the particular subject failed to meet the specified criterion on this test, he/she was immediately excluded from the sample. All testing and interviewing was done in English. Because of the lengthy nature of the battery being used, testing was broken up into two sessions and occurred within the first forty-eight hours after the resident was admitted to the home. Where necessary, staff and nursing

notes were consulted for information as to the resident's current physical and mental level of functioning. A careful check was made to see that all subjects fulfilled the criteria specified to participate in this study.

Each subject was told that the research program was designed to learn more about how people felt when going to an aged home for the first time and what their feelings were when they had been there a short while. It was explained that the present study might be of help to them during what normally is an extremely difficult period and, furthermore, it might be of help to elderly people in the future who would be going through the same experience that they were currently undergoing. All subjects were assured of confidentiality in all phases of the program.

Step two in the program was set into motion a day after the initial battery of tests had been completed. The respective therapist introduced herself to the aged person in question explaining that she was also part of the research team designed to learn more about how people felt when coming into an aged home. She outlined what her role was to be and drew up a contract specifying the limits and duration of her participation in the study. The treatment in both cases was carried out for five weeks after which the test administrator returned to complete his post-test investigation. This corresponded to the commencement of the resident's sixth week in the home. Testing was once again broken up into a two-day period and upon completion, subjects were told that the test administrator would be in to see them in six weeks time when a follow-up battery would be carried out.

At the commencement of the third month of residency the third and final stage of the procedure was enacted when a follow-up battery was carried out. The same tests that were used in the previous assessments were administered once again. After the experiment had been completed and if residents then required any further intervention their future management was discussed with ward staff and long-term plans drawn up.

CHAPTER 7



Results. Statistical Analysis.

7.1 Introduction

An experiment was conducted to observe the effect of two external treatments on the adjustment of White South African Geriatric residents, fluent in the English language, to living in residential old age homes in the Western Cape area of South Africa.

Measurements were made on biological, social and psychological aspects on a sample from this population during the first three months of their residence in one of nine randomly selected institutions.

All variates were subjected to analysis using the technique of Analysis of Variance, and the psychological variates were also analysed under Multivariate Analysis of Variance and Discriminant Function Analysis.

The two treatments, Crisis Intervention (CI) and Social Activity (SA) were found to have an effect on adjustment different to that of a control group. The CI group, in comparison with the Control Group was most markedly different, causing opposite trends in most of the variates.

7.2 The Data :

The data consist of measurements made on 90 subjects from nine homes (Table 7.2.1). The subjects were divided into nine groups, three for each home, with equal numbers in each group for each home. This division did not regard sex or age in any way.

A group from each home was assigned to each of three treatment groups (Table 7.2.2).

There are 92 variates and factors in the data set. These have been given mnemonics for the analysis, and a list of these, together with their corresponding variates, is given in Appendix 1.

Table 7.2.1 - Number of Subjects from Each Home

Home	Subjects
1. Home A	9
2. Home B	15
3. Home C	6
4. Home D	9
5. Home E	6
6. Home F	18
7. Home G	6
8. Home H	15
9. Home I	6

Table 7.2.2 - Number, Sex and Mean Age of Subjects
in each Treatment Group

Treatment	Females	Males	Ave. Age
1. Control	25	5	75.7
2. Crisis Intervention	25	5	75.9
3. Social Activity	23	7	76.7
			SE 1.10

Data from psychological experiments should come from a normal distribution, however, the measurement of these variates is often very coarse, more a classification than measurement, and this gives these variates a discrete distribution character. Problems will be encountered if the classification is so broad that there is little or no variation in some of the cells of the design. This has occurred in several of the variates in this study and these must be largely discarded. These variates are : BLM3; BLM4; PR07 and PRL2.

With the other variates their discrete nature means that the F value in analysis of variance may not be distributed exactly according to the F distribution. However, the F test is known to be robust, and we need only worry about borderline significance. Fortunately, in this study effects seen to be mostly clearly significant or not at all.

Seven factors BAGE, BSEX, SMST, SYRW, SEDL, SCOP and SFIN have been measured although they are not part of the design of the experiment. Analysis shows that these factors are associated with many of the variates in the experiment but it is not possible to determine their effect on adjustment due to non-orthogonality with treatment and assessment.

Several of these factors are also correlated with Home and cannot be distinguished from that effect.

These factors should not affect the results of the experiment since they were not regarded in the allocation of subjects to cells and so should be equally represented in each cell.

7.3. Method of Analysis

The variates in the data set have been divided into five classes, each being analysed separately although in some cases with the same model.

The classes are :

- (i) Social variates measured only prior to commencement of treatment.
- (ii) Character profile variates.
- (iii) Biological variates.
- (iv) Social variates measured at each assessment.
- (v) Psychological variates.

All variates were analysed by the analyses of variance technique, and then the psychological variates were analysed as a group, using multi-variate analysis of variance and Discriminant Function Analysis.

Underlying both methods of analysis is the fitting of a linear model to the data and Scheffe (1959) provides a general reference.

7.3.1 Model for Analysis of Variates Measured Prior to Commencement of Treatment Only.

This model was used to analyse variates in Classes (i) and (ii) above.

There are two factors in the design for these variates, Treatment and Home.

Treatment is a fixed effect because the treatments were chosen for cheapness, convenience, unskilled administration and lack of side effects so that they are not a random choice representative of some class of treatments available. This applies to all models in the analysis and means that conclusions reached in the analysis are only applicable to the chosen treatments.

The Home factor is random because the homes used in the experiment were randomly chosen from those in the Western Cape area admitting English speaking residents. Thus conclusions may be considered to represent this type of home.

The subjects in the analysis are also a random factor, being a random sample from old age people able to speak English and take up residency in the class of homes considered. The class they represent is also restricted by certain medication limitations, and reasoning ability.

The model for this analysis is :

$$X(ijk) = M + T(i) + H(j) + TH(ij) + E(ijk) \dots (7.3.1)$$

Where : $X(ijk)$ is the value of a variate measured on the k th subject in the i th treatment group, and j th home.

M is the mean value of the variate.

$T(i)$ is a component due to the i th treatment.

$H(j)$ is a component due to the j th home.

$TH(ij)$ is a component due to interaction between the i th treatment and j th home.

$E(ijk)$ is the residual error effect.

Table 7.3.1 - Analysis of Variance Table for Model 7.3.1

Source	D.F.	Expected Mean Square
Treatment	2	$270 V(T) + 30 V(TH) + V(E)$
Home	8	$90 V(H) + V(E)$
Treat. x Home	16	$30 V(TH) + V(E)$
Residual	63	$V(E)$
Total	89	
Mean	1	

$V(x)$ is the variance of the effect parameter x .

The derivation of the model, degrees of freedom and Expected Mean squares is explained in Scheffe (1959, pp.282-289).

The error effect to test the hypothesis that there is no difference between treatment groups with respect to these variates is the treatment x home interaction.

The Residual effect is used to test the hypotheses that there is no difference between homes, and that any differences between treatments are the same for each home.

7.3.2 Model for Analysis of Variates measured at each Assessment

(a) Analysis for each assessment separately.

The model (7.3.1) was used on the data at each assessment to check treatment differences at each stage of assessment.

(b) Analysis for each treatment separately.

Within each treatment group we have two factors, Assessment and Home. The Home factor was discussed in 7.3.1.

The Assessment factor is ambiguous as to its status of fixed or random. In this model, however, it will make no difference to the tests involved, only to the applicability of the conclusions. This problem will be discussed further in the next section.

The model is :

$$X(ijk) = M + A(i) + H(j) + AH(ij) + E(ijk) \dots 7.3.2.$$

$A(i)$ is a component due to the i th assessment

$AH(ij)$ is a component due to the interaction of assessment with home.

The other parameters hold the same definitions as in 7.3.1. except the i applies to assessment.

The Analysis of Variance table is exactly as Table 7.3.1. with Treatment and T replaced by Assessment and A respectively.

The hypothesis that within each treatment there is no change from one assessment to the next is tested against the interaction.

(c) Analysis over treatment and assessment.

Model :

$$\begin{aligned} X(ijkl) = & M + T(i) + A(j) + TA(ij) \\ & + H(k) + TH(ik) + AH(jk) + TAH(ijk) \\ & + S(l(ik) + E(ijkl) \dots \dots \dots (7.3.3.) \end{aligned}$$

All parameters have the same definitions as in 7.3.1 and 7.3.2.

$S(l(ik))$ is a component due to being the l th subject within the i, k th treatment - home cell. (Nested)

This is not an interesting component because there is no doubt that the treatment - home cells will differ with respect to subject because they contain different people. However, it is a block effect and will remove considerable variation from some of the error terms.

The factor represented by 'S' is the difference between subjects and is random as discussed in 7.3.1.

The Assessment factor as discussed earlier can be regarded as fixed or random.

Strictly speaking it is fixed, because the time and number of assessments were not picked randomly but to be convenient.

However, we are interested in the state of adjustment at other times than those used and so the random effects model will be considered as well as the fixed effect model which is the statistically correct one (Rayner, 1967, pp.200).

Table 7.3.2 - Analysis of Variance Table for Model 7.3.3.
with Treatment and Assessment fixed, Home
and Subject Random

Source	D.F.	Expected Mean Squares
Treatment	2	$810 V(T) + 90 V(TH) + 3 V(S) + V(E)$
Assessment	2	$810 V(A) + 90 V(AH) + V(E)$
Treat. x Assm.	4	$270 V(TA) + 30 V(TAH) + V(E)$
Home	8	$270 V(H) + 3 V(S) + V(E)$
Treat x Home.	16	$90 V(TH) + 3 V(S) + V(E)$
Assm. x Home	16	$90 V(AH) + V(E)$
Treat x Assm x Home	32	$30 V(TAH) + V(E)$
Subj.in Treat x Home	63	$3 V(S) + V(E)$
Residual	126	$V(E)$
Total	269	
Mean	1	

Treatment is tested against (Treatment x Home); Assessment against (Assessment x Home); (Treatment x Assessment) against (Treatment x Assessment x Home); Home against Subject, (treatment x Home) against Subject and (Assessment x Home) and (treatment x Assessment x Home) against Residual.

There are several special comparisons which can be made on the present data set. Testing these comparisons involves forming linear functions of the data means and dividing the analysis of variance of Table 7.3.2 further. The procedure for this part of the analysis is discussed in Rayner (1967, Chap.11). The sums of squares and degrees of freedom are orthogonally partitioned so as to test the special hypotheses.

The Treatment groups comprise a control and two treatments so the two degrees of freedom are used to test firstly is there is any difference between the control and the two treatments together and secondly, if there is any difference between the two treatments themselves, i.e., Crisis Intervention (CI) and Social Activity (SA).

The two degrees of freedom for Assessment can be partitioned to test firstly if there is any difference between Assessment 2, at the end of treatment, and Assessments 1 and 3. In other words, do the variates revert to pre-treatment state after Assessment 2. Secondly, is there a difference between Assessment 1 and 3.

The four degrees of freedom for Treatment x Assessment can be conformably partitioned into effects :

Assessment 2 vs. 1 and 3 Control vs. Treatments.

Between Assessments 1 and 3 x Control vs. Treatments.

Assessment 2 vs. 1 and 3 x Between Treatments.

Between Assessments 1 and 3 x Between Treatments.

The hypotheses tested by these comparisons are discussed in Section 4.5.2 (c).

Table 7.3.3 - Analysis of Variance Table for Model 7.3.3
with Treatment Fixed, Assessment, Home and
Subject Random.

Source	D.F.	Expected Mean Squares
Treatment	2	$810 V(T) + 270 V(AT) + 90 V(TH) + 30 V(TAH) + 3 V(S) + V(E)$
Assessment	2	$810 V(A) + 90 V(AH) + V(E)$
Treat x Assm	4	$270 V(AT) + 30 V(TAH) + V(E)$
Home	8	$270 V(H) + 90 V(AH) + 3 V(S) + V(E)$
Treat x Home	16	$90 V(TH) + 30 V(TAH) + 3 V(S) + V(E)$
Assm x Home	16	$90 V(AH) + V(E)$
Treat x Assm x Home	32	$30 V(TAH) + V(E)$
Subj. in Treat x Home	63	$3 V(S) + V(E)$
Residual	126	$V(E)$
Total	269	
Mean	1	

In the Analysis with Assessment random, Table 7.3.3 it is seen that the effects Treatment, Home and (Treatment x Home) have no natural error terms. In this case only an approximate F test can be made by pooling terms to form an error. For treatment, (Treatment x Assessment) + (Treatment x Home) - (Treatment x Assessment x Home) forms an error.

For Home, (Assessment x Home) + (Subject) - (Residual) forms an error.

For (Treatment x Home), (Treatment x Assessment x Home) + (Subject) - (Residual) forms an error.

The error degrees of freedom will also change as explained in Scheffe (1959, pp.247).

This analysis was used to get a comparison with the fixed effect case. The partitioning of the degrees of freedom to test specific hypotheses was not carried out in this case.

7.3.3. Multivariate Analysis of Variance on the Psychological Variates.

In order to determine the effect of the factors over all psychological variates, viewed simultaneously, a multivariate analysis of variance was undertaken on a simpler form of model (7.3.3) and table (7.3.2).

Multivariate analysis of variance fits exactly the same kind of model as the single variate case but the test statistic involves the ratio of the determinant of the error sum of squares and cross products matrix (E) to the determinant of the sum of E and the effect SSCP matrix (H).

$$\text{Lambda} = |E|/|E + H|$$

(Tatsuoka, 1971, chaps. 4 & 7).

H in our case will only have rank equal to the degrees of freedom of the effect and so will be singular, thus to get a non-zero determinant in the denominator E must be non-singular. In general E will have to have more degrees of freedom than the number of variates under test for this to be possible. In our example this will require pooling of some of the interaction effects involving Home. This will be quite valid provided we can assume these effects zero, and this will be tested in the univariate analysis.

The model for the analysis will be :

$$\begin{aligned} X(ijkl) = & M + T(i) + A(j) + TA(ij) \\ & + H(k) + S(l(ik)) + E(ijkl) \dots (7.3.4) \end{aligned}$$

The Analysis of Variance Table for Model (7.3.4) will be the same as Table 7.3.2 with the 5, 6 and 7th rows deleted; all variance terms in the expected mean squares column involving TH, AH and TAH are zero and the degrees of freedom for subject and residual become 79 and 174 respectively. The 'V's now represent covariance matrices.

The error term for Treatment becomes Subject (79 degrees of freedom for 48 variates) and similarly for Home, while the other effects are tested against Residual (174 D.F.).

7.3.4 Discriminant Function Analysis on the Psychological Variates

When in the Multivariate Analysis of Variance an effect is found significant it is possible to calculate the coefficients of a linear function of all the variates which will discriminate most between the different levels of the effect.

(Cooley and Lohnes, 1971, Chap. 9., and Tatsuoka, 1971, Chap. 6).

7.4. Results

7.4.1 Social Variates Measured only prior to Commencement of Treatment

There is no significant difference between the three treatment groups with respect to marital status, years widowhood, educational level, occupation, and financial status.

In the case of the last three factors, this lack of significance is probably due to their high correlation with choice of home which was a factor in the experiment and is thus totally confounded with these effects.

The effect of years widowhood and marital status on the adjustment of the subjects is not possible to assess since these factors were not a criterion in the experimental design and so are not orthogonal to the other factors, Treatment, Assessment and Home.

7.4.2 Character Profile Variates

There is/no significant difference between the three treatment groups with respect to any of the Character Profile Variates.

Twelve of these variates are significantly different amongst the homes (Table 7.4.1). This means that it is not possible to examine adjustment in the light of character variates independently of the choice of home.

Table 7.4.1 - Level of Significance of Character Profile Variates between Homes

Variate	Significance %
C P O 1	5
C P O 2	1
C P O 3	
C P O 4	5
C P O 5	
C P O 6	
C P O 7	
C P O 8	0.5
C P O 9	5
C P 1 0	
C P 1 1	0.5
C P 1 2	0.5
C P 1 3	0.5
C P 1 4	0.5
C P 1 5	0.5
C P 1 6	0.5
C P 1 7	5

7.4.3 Biological Variates ○

The biological variates show strong discrete variate characteristics and will thus tend not to be normally distributed so that the F values in the analysis of variance model(7.3.3) will not have true F distribution. As a result of this the probability statements attached to these values are in doubt and will only provide an indication of where differences lie within the data.

Variates BLM3 and BLM4 showed so little variation that they are excluded from the analysis.

(a) Treatment

There is no significant difference between treatment groups with respect to any of the biological variates at any single level of assessment nor over all levels of assessment.

There is no significant difference between the control and the other two treatment groups nor between the two treatment groups - Crisis Intervention and Social Activity, with respect to any biological variate.

(b) Assessment.

With respect to biological variates, there is again no significant difference between assessments at any single level of treatment, or over all treatments, there is also no significant difference between Assessment 2 (at the end of treatment) and Assessments 1 and 3 nor is there any difference between Assessments 1 and 3.

(c) Treatment x Assessment

With respect to the biological variates, there was no significant

difference in the way values changed with assessment from one treatment to another.

All the single linear function comparisons were also non significant except in one case.

Variate BLMI, the Lefevre Morbidity Pain Scale showed a significant difference at the 0.5% level for one particular comparison. The CI group show a decrease in BLMI from assessment 1 to 3 while the SA group increase. The control group decrease slightly although this comparison is not significant (Table 7.4.2).

Table 7.4.2 - Interaction between treatment
groups and assessments 1 and 3, for
Variate BLMI.

Treatment	CI	SA	CONT.
Assessment 1	0.90	1.03	1.07
Assessment 3	0.83	1.10	1.03

SE of a mean in the table .030

No. of values in each mean - 30

This difference, however, was achieved by one subject in the control group changing from a value of 3 to 2, one in the CI group changing from 3 to 1 and three in the SA group changing from 1 to 3, 3 to 2, and 0 to 1.

(d) Home

Six of the biological variates are significantly different between

different homes (Table 7.4.3).

This implies that the residents in homes differ with respect to characteristics such as morbidity, self dependence and physical infirmness. This may be due to choice of applicants by the administration of the homes.

Table 7.4.3 - Analysis of Variance Results for
Factor Home on the Biological Variates.

Variate	Significance %
BLM1	5
BLM2	5
BLM5	0.5
BLM6	
BPSM	0.5
BPS1	0.5
BPS2	
BPS3	
BPS4	0.5

7.44 Social Variates Measured at each Assessment

(a) Treatment

There is no significant difference between the three treatment groups with respect to significant caring (SSCA), family involvement (SFAI) and community involvement (SCOI) at one single level of assessment or over all assessments.

There is no significant difference in any of these variates between

the control group and the treatment groups together.

The community involvement variate SCOI, shows a difference, significant at the 5% level between the CI group and the SA group. The CI group is the most extreme of the three groups (Table 7.4.4).

Table 7.4.4 - Treatment Means for
Variate SCOI.

Treatment	Mean
Control	4.25
CI	4.82
SA	4.03

Means of 90 values SE - 0.256

(b) Assessment

Considering the assessment means for each treatment group separately we find that community involvement (SCOI) shows significant differences at the 0.5% level in the control and CI groups. The means for each group are plotted in Appendix 2 and it can be seen that the control group decreases with respect to this variate while the CI group increases over assessments.

The significant caring variate (SSCA) differs significantly at the 5% level between assessments in the CI group. The mean changes from 4.90 at Assessment 1 to 5.20 at Assessment 3 (S.E. 0.076).

Considered over all treatment groups, there is no significant difference between assessments in these variates.

There is no significant difference between Assessment 2 and Assessments 1 and 3 nor between Assessments 1 and 3 for any of these variates.

(c) Treatment x Assessments

All three variates show a significant interaction between treatment and assessment (SSCA and SFAI at 5%, SCOI at 0.5%). The interactions are plotted for each variate in Appendix 2.

The nature of the interaction is clarified by considering the special comparisons in all three variates - the comparison (between Assessment 1 and 3) x (between treatments) is significant. 5% for SSCA and SCOI, 0.5% for SFAI. This means that the difference in trend from Assessment 1 to 3 was not the same in the CI group as the SA group. Again this is shown in the graphs of Appendix 2.

In the case of SCOI the comparison (between Assessment 1 and 3) x (Control vs Treatments) is also significant at the 0.5% level. Thus for this variate the trend over Assessments is different in the control group to that in the treatment groups.

The lack of significance in the other effects indicates that the trends over assessment are consistent from Assessment 1 to 2 and 2 to 3 and do not change direction significantly.

(d) Home

Only the community involvement score, SCOI is significantly different (0.5%) between homes (Table 7.4.5).

Table 7.4.5 - Home Means for Variate SCOI

Home	No. Values	Mean	S.E.
A	54	4.33	0.038
B	18	5.17	0.066
C	18	6.17	0.066
D	18	5.78	0.066
E	45	3.91	0.042
F	27	3.07	0.054
G	45	4.29	0.042
H	27	5.11	0.054
I	18	2.67	0.066

7.4.5 Psychological Variates

These variates show considerably more variation and continuous nature than the biological or social variates.

The variate PR12 was constant over all classes of the design and PR07 was constant over assessment in all treatment groups. These variates were excluded from the analysis.

7.4.5.1 Multivariate Analysis of Variance and Discriminant Function Analysis.

Because of the greater variability and more continuous nature of the psychological variates a multivariate analysis of variance using the model (7.3.4) was performed. The significant effects from this analysis were subjected to Discriminant Function Analysis to produce an overall measure of psychological adjustment in the form of the significant discriminant functions.

As discussed in Section 7.3.3 the interactions of Model 7.3.3 had to be pooled with subject and residual in order to provide non-singular error matrices. The validity of this is discussed in 4.5.2 (e).

The results for the multivariate analysis of variance are given in Table 7.4.6.

(a) Treatment

There is no significant difference between the treatment groups over all assessments with respect to the whole group of psychological variates.

Table 7.4.6 - Results for Multivariate Analysis of
Variance of the Psychological Variates

Effect	Wilks Lamda	Effect D.F.	Error D.F.	F Value	Numerator D.F.	Denominator D.F.
Treatment	0.194	2	79	0.84	96	64
Assessment	0.150	2	174	4.19	96	254
Treat x Assm	0.161	4	174	1.54	192	509
Home	0.001	8	79	0.97	384	271
Subject	0.000	79	174	14.82	1000	5860

(b) Assessment

From Table 7.4.6 the assessment effect is significant at better than the 0.5%. In other words, the psychological variates change over assessment over all treatment groups.

Only the first discriminant function is statistically significant at 0.5%. This function accounts for 93% of the discriminating power of the sample (This is measured by the ratio of the eigen value of $(E \text{ inverse} * H)$

corresponding to the discriminant function to the trace of that matrix.

E and H as defined in 7.3.3(Cooley and Lognes, 1971, pp.253).

The values of the standardised discriminant function of means for each assessment are :

Assessment 1 - 2.21.

Assessment 2 - 0.61.

Assessment 3 - 1.61

Assessment coinciding with the end of treatment shows the most extreme value.

(c) Treatment x Assessment

There is significant difference at the 0.5% level for the treatment x assessment interaction. In other words, the change over assessments in the psychological variates is not the same for all treatment groups.

Only the first of the four discriminant functions is significant 0.5%.

Thus discriminant function accounts for 55% of the discriminating power of the sample and provides the most sensitive measure of change between assessment for each treatment in the psychological variates. This interaction is shown in fig. 1 where the treatment by assessment group mean standardised discriminant function values are plotted.

It is quite clear that the CI group shows the markedly different trend. The psychological index value drops over assessment, while in the control group, it rises.

It is not possible to decide whether this index indicates good or bad psychological adjustment in the CI group, only that it is different. The other aspect can be investigated in the univariate analysis of psychological data.

(d) Home

The psychological variates as a group are not significantly different between different homes.

(e) Subject within treatment by home

This effect measures the difference between subjects from one treatment-home cell to another. As expected this effect is very highly significant and so it a useful block effect in the design models (7.3.3) and (7.3.4).

It is also interesting to note that in the Discriminant Function Analysis 43 discriminant functions are significant. Thus in the 48 variates analysed only 5 statistical dimensions were duplicated.

7.4.5.2 Univariate Analysis of Psychological Variates using Model (7.3.3) with Effects Treatment and Assessment Fixed, Home and Subject Random

(a) Treatment

No variate is significant between treatments as Assessment 1. This indicates that the treatment groups were uniform with respect to the psychological variates before treatment was applied.

At Assessment 2, 10 variates are significant at the 5% level, and 4 at 1%.

At Assessment 3, 6 variates are significant at the 5% level, 3 at 1% and 9 at 0.5%. Thus the treatment groups diverged consistently after Assessment 1.

Over all assessments 6 variates are significant at the 5% level, 1 at 1% and 1 at 0.5%.

These results are shown in Table 7.4.7. The means of the psychological

variates for each treatment are given in Appendix 3.

Considering the linear comparisons, control versus CI and SA groups and between CI and SA groups, we find from Table 7.4.7 that in each case 5 variates were significant at the 5% level and 1 at the 0.5% level.

(b) Assessment

Significance levels for assessment in each of the treatment groups are shown in Table 7.4.8. It is interesting to note that in the control group 15 variates were significant, in the CI group 32 were significant and in the SA group 7. This coincides with the conclusions from the multivariate studies that the CI group shows most response to the treatment. This will be considered further in the next section.

Over all treatments 28 variates show significance, 20 at the 0.5% level 1 at the 1% and 7 at 5%. There is clearly considerable change in the psychological variates from one assessment to another. The means and SEs for assessment are shown in Appendix 4.

In the comparison of Assessment 2 and Assessments 1 and 3, 11 variates are significant while in the comparison between Assessments 1 and 3, 30 are significant which indicates that trends in the variates tend to continue with assessment and do not revert back towards the Assessment 1 levels during the time between Assessments 2 and 3. These results are shown in Table 7.4.8 and can be seen clearly in the assessment means in Appendix 4 where 35 variates of the 48 have values at Assessment 2 between those of Assessments 1 and 3.

The psychological significance of this effect lies in checking whether the trends in most variates are towards better or worse adjustment.

Table 7.4.7 - Level of Significance for Treatment Effect on the Psychological Variates

Variate	Treat at Ass 1	Treat at Ass 2	Treat at Ass 3	Treat All Ass	Cont.vs Treat 2 & 3	Between Treat 2 & 3
P G M S						
P B G E						
P R B E						
P L S A						
P S R A		5	5			
P R Ø 1						
2		5	0.5			
3						
4						
5						
6		5	0.5		5	
8						
9			0.5			
10			5			
11		5	0.5	5		5
13						
14			5		5	
15						
16						
17						
18						
P O S E						
P I B 1		5	5			
2		1	1	5		5
3		1	0.5	5	5	
4		5	0.5	0.5	5	0.5
5		1	5	5	5	
P S A C						
P P M 1		5	1	5		5
2						
3		5	0.5			5
4						
5						
6						
7						
8		5	0.5	5		5
P L Ø 1						
2						
3						
4						
5						
6			5			
7						
8						
9						
10						
P T A 1		1	0.5	1	0.5	
2		5	1			

Table 7.4.8 - Significance level for Assessment Effects
on the Psychological Variates.

Variate	Assm at Treat 1	Assm at Treat 2	Assm at Treat 3	Assm over all Treats	Assm 2 vs 1 & 3	Between Assm 1 & 3
P G M S		5		5		1
P B G E		0.5		5		5
P B D E		1				
P L S A		0.5		0.5		0.5
P S R A		0.5				
P R Ø 1		0.5				
2		0.5	5	0.5	5	0.5
3						
4		0.5		5		1
5	5	0.5		0.5		0.5
6		0.5		5		1
8						
9		0.5	5	0.5	5	0.5
10	5	0.5				
11	0.5	0.5				
13		0.5		0.5		0.5
14	5					5
15	0.5			0.5		0.5
16		0.5	5	0.5	0.5	0.5
17	5	0.5				
18	0.5	0.5	0.5	0.5	0.5	0.5
P O S E		0.5		0.5		0.5
P I B I		0.5		0.5		0.5
2		0.5		0.5	0.5	0.5
3		0.5	0.5	0.5	0.5	0.5
4		0.5		0.5	1	0.5
5		0.5	0.5	0.5	0.5	0.5
P S A C		0.5		0.5		0.5
P P M 1	0.5	5		5		0.5
2	0.5			5		1
3		0.5		0.5		0.5
4						
5	1	0.5				
6		0.5				5
7	5	1				
8	5	0.5				
P L O 1	5			1		0.5
2	5			0.5	5	0.5
3						
4						
5				5		1
6						
7		5				
8	5			0.5		0.5
9						
10						
P T A 1		0.5	5	0.5	0.5	0.5
2		0.5		0.5	0.5	0.5

(c) Treatment by Assessment Interaction

This is psychologically the most important effect in the design because it compares the way in which adjustment changes with assessment in each treatment group.

As pointed out in the multivariate study, the effect is highly significant. The significance levels for the univariate case are in Table 7.4.9 for the overall effect and the specific comparisons in the design.

Overall 32 variates show significance, 25, at the 0.5% level.

All these effects are graphically represented in Appendix 2. 23 variates show the CI group adjustment in the opposite direction to the control group while in the SA group 13 show this trait. This indicates the CI treatment has had a marked effect on adjustment and it remains to examine the direction of this change to see if it has had a psychologically desirable or undesirable effect.

We can examine this effect more clearly through the linear comparison effects of the model, the results of which are shown in Table 7.4.9.

The null hypothesis tested by the comparison (Assessment 2 vs. 1 and 3) x (control vs. treatments) is that the comparison between the Assessment 2 values and the Assessment 1 and 3 values is the same in the control group as in the other two groups. Practically in this experiment this tests whether the trend in adjustment over assessment has been consistent both in the control group and in the two treatment groups. Note it does not test whether it has been in the same direction, only whether it has changed direction within either group.

This null hypothesis is accepted in all but seven cases which ties

in with earlier observation that the Assessment 2 mean is nearly always between the Assessment 1 and 3 means.

The comparison (between Assessment 1 and 3) x (control versus treatments) tests the null hypothesis that the trend between Assessment 1 and 3 is the same in the control and treatment groups. This hypothesis is strongly rejected, 26 variates significant at the 0.5%; 3 at the 1% and 4 at the 5% level. This supports the earlier observation that the CI and SA adjustment direction were different to that in the control group.

The comparison (assessment) x (control versus treatments) combines the previous two hypotheses and derives its significance or otherwise from the results of those hypotheses.

The comparison (assessment 2 versus 1 and 3) x (between treatments) tests the null hypothesis that the direction of adjustment in the CI and SA groups does not change.

Note : not that the direction is the same in the two groups.

Once again this hypothesis is largely accepted, only one variate, PTAl showing significance at the 5% level.

The comparison (between Assessment 1 and 3) x (between treatments) tests the null hypothesis that the direction or slope of adjustment between Assessment 1 and 3 is the same in the CI and SA groups. This hypothesis is rejected in 24 variates at the 0.5% level, 1 at the 1% and 6 at the 5% level. This indicates strongly that the treatments differ in their effect on adjustment and observing that the SA group agrees in direction with control more often than the CI group; this fact indicates that the CI treatment is the outstanding one. Again the direction with respect to each variate must be examined to see if the treatment has had a desirable or detrimental effect.

The comparison (assessment) \times (between treatments) combines the previous two hypotheses and derives any significance from them.

Table 7.4.9 - Level of Significance for Treatment by
Assessment Interaction effect on the
Psychological Variates

Variate	Assm x Treat	Ass 2 vs 1 & 3 x C vs Treat	B Ass 1 & 3 x C vs Treat	Ass x C vs Treat	Ass 2 vs 1 & 3 x B Treats	B ass 1 & 3 x B Treats	Ass x B Treats
P G M S			1	5			
P B G E							
P B D E	0.5		0.5	0.5		0.5	0.5
P L S A	5		0.5	5			
P S R A	0.5		0.5	0.5		0.5	0.5
P R Ø 1	0.5		0.5	0.5		0.5	0.5
2	0.5		0.5	0.5		0.5	0.5
3			5				
4							
5	0.5		0.5	0.5		0.5	0.5
6	0.5	1	0.5	0.5		0.5	0.5
8			5				
9	0.5		0.5	0.5		0.5	0.5
10	0.5		0.5	0.5		0.5	5
11	0.5		0.5	0.5		0.5	1
13	0.5	5	0.5	0.5		0.5	0.5
14	5		0.5	1			
15	5		1	5			
16	0.5	5	0.5	0.5		0.5	1
17	0.5		0.5	0.5		0.5	5
18						5	5
P O S E	5					0.5	5
P I B 1	1		5	5		5	5
2	0.5	5	0.5	0.5		5	5
3	0.5	1	0.5	0.5		0.5	0.5
4	5		1	5			
5	0.5	5	0.5	0.5		0.5	0.5
P S A C	0.5		0.5	0.5		0.5	0.5
P P M 1	0.5		0.5	0.5		5	
2	0.5		0.5	1		1	5
3	0.5		0.5	0.5		0.5	0.5
4						5	
5	0.5		0.5	0.5		0.5	1
6	0.5		0.5	0.5		0.5	5
7	1		5			0.5	1
8	0.5		0.5	0.5		0.5	0.5
P L O 1							
2							
3							
4							
5							
6							
7	0.5					0.5	0.5
8						5	
9							
10							
P T A 1	0.5	5	0.5	0.5	5	0.5	0.5
2	0.5		0.5	0.5		0.5	0.5

(d) Home

There is considerable difference between subjects in particular homes with respect to several psychological variates.

These are listed with their level of significance in Table 7.4.10.

The means are presented in Appendix 5.

Table 7.4.10 - Level of Significance for Effect
Home on the Psychological Variates

Variate	Significance %	Variate	Significance %
P G M S	0.5	P I B 3	0.5
P G B E	0.5	P I B 4	5
P B D E	0.5	P I B 5	
P L S A	0.5	P S A C	1
P S R A	0.5	P P M 1	0.5
P R Ø 1		P P M 2	1
P R Ø 2	5	P P M 3	5
P R Ø 3		P P M 4	5
P R Ø 4		P P M 5	0.5
P R Ø 5		P P M 6	
P R Ø 6		P P M 7	0.5
P R Ø 8		P P M 8	0.5
P R Ø 9	0.5	P L Ø 1	
P R 100	0.5	P L Ø 2	
P R 1 1	0.5	P L Ø 3	
P R 1 3	5	P L Ø 4	5
P R 1 4		P L Ø 5	
P R 1 5		P L Ø 6	
P R 1 6		P L Ø 7	5
P R 1 7		P L Ø 8	
P R 1 8	5	P L Ø 9	
P O S E	0.5	P L 1 0	
P I B 1	0.5	P T A 1	5
P I B 2	5	P T A 2	5

(e) Interactions of Home with Treatment and Assessment

There is no significant interaction between Home and treatment or between Home and assessment. However, three variates, PLSA, PIB2 and PIB4

show significant interactions between treatment by assessment at home at the 5% level. The difficulty in ascribing any meaning to this interaction and the low level of significance suggests that it can be ignored.

Over all these interactions the lack of significance indicates that it is acceptable to pool them with the subject within (home x treatment) effect and residual which are then the error terms for the experiment. This pooling was discussed with respect to the multivariate analysis in Sections 7.3.3. and 7.4.5.1.

7.4.5.3 Univariate Analysis of Psychological Variates using Model (7.3.3) with effect Treatment fixed and Assessment, Home and Subject Random.

As discussed in Section 7.3.2 (c) this model is not statistically correct but it is interesting to observe any differences in results if this model is assumed.

Comparing Tables 7.3.2 and 7.3.3 we see that only the calculation of the F values for effects Treatment, Home and Treatment x Home changes. Thus for all other effects the results are identical.

For the effects, Home and Treatment by home no single variate changed in significance level so the results are identical here.

For the effect Treatment, all 8 significant variates under the first model became non significant under this one. In other words, there was no significant difference between the treatment groups.

The most important effect in the experiment is the Treatment x Assessment effect and as stated earlier the results are identical for both models.

It must be noted, however, that although the results change little, the interpretation changes. Under the correct model we can only consider

results to pertain to the exact situation of the experiment; in other words, adjustment over a six week period of treatment with a follow up measure of adjustment at three months.

7.5 Summary of Results

The character profiles and social status of each treatment group as measured before commencement of treatment were the same.

The Biological Variates measured at each assessment show too little variability between design cells to be of use in evaluating the differing treatment methods.

The Social Variates measured at each assessment and the Psychological Variates indicate clearly that the three treatment groups adjusted in different fashion.

The Crisis Intervention Group appears to differ more from the Control Group than the Social Activity Group. In many variates it shows reverse trends opposite those of the Control Group.

In all treatments, the initial variate means were not different but diverged consistently from Assessment 1 to 2 and 2 to 3. More variates continued to diverge from Assessments 2 to 3 than reverted back towards Assessment 1 levels.

MNEMONICS USED FOR VARIATES AND FACTORS

MNEMONIC	VARIATE OR FACTOR	MNEMONIC	VARIATE OR FACTOR
1. TRET	Treatment	47. PSAC	Bells Social Involvement
2. ASSM	Assessment	48. PPM1	Mental Scales of PAMIE
3. SUBJ	Subject	49. PPM2	" "
4. HOME	Home	50. PPM3	" "
5. BAGE	Age	51. PPM4	" "
6. BSEX	Sex	52. PPM5	" "
7. BLM1	Lefevre Morbidity P	53. PPM6	" "
8. BLM2	" " D	54. PPM7	" "
9. BLM3	" "	55. PPM8	" "
10. BLM4	" "	56. PLØ1	Lieberman Self Sort
11. BLM5	" "	57. PLØ2	"
12. BLM6	" "	58. PLØ3	"
13. BPSM	Physical Self Maintenance	59. PLØ4	"
14. BPS1	Self Care Dependence	60. PLØ5	"
15. BPS2	Bedfast Moribundness	61. PLØ6	"
16. BPS3	Sensory Motor Impairment	62. PLØ7	"
17. BPS4	Physical Infirmitess	63. PLØ8	"
18. PGMS	Goldfarbs Mental Status	64. PLØ9	"
19. PBGE	Bender Gestalt	65. PL10	"
20. PBDE	Becks Depression Inventory	66. PTAL	TAT Affective Responsiveness
21. PLSA	Life Satisfaction Index	67. PTA2	"
22. PSRA	Subjective Adjustment Rating	68. CPØ1	Cattell Personality"Factor
23. PRØ1	Brief Psychiatric Rating Scale	69. CPØ2	" "
24. PRØ2	"	70. CPØ3	" "
25. PRØ3	"	71. CPØ4	" "
26. PRØ4	"	72. CPØ5	" "
27. PRØ5	"	73. CPØ6	" "
28. PRØ6	"	74. CPØ7	" "
29. PRØ7	"	75. CPØ8	" "
30. PRØ8	"	76. CPØ9	" "
31. PRØ9	"	77. CP10	" "
32. PR10	"	78. CP11	" "
33. PR11	"	79. CP12	" "
34. PR12	"	80. CP13	" "
35. PR13	"	81. CP14	" "
36. PR14	"	82. CP15	" "
37. PR15	"	83. CP16	" "
38. PR16	"	84. CP17	" "
39. PR17	"	85. SMST	Marital Status
40. PR18	"	86. SYRW	Years Widowhood
41. POSE	Osgood Self Evaluation	87. SEDL	Education Level
42. PIB1	Interpersonal Behaviour	88. SOCP	Occupational Status
43. PIB2	" "	89. SFIN	Financial Status
44. PIB3	" "	90. SSCA	Significant Caring
45. PIB4	" "	91. SFAI	Family Involvement
46. PIB5	" "	92. SCOI	Community Involvement

Results. Graphic Interpretation.

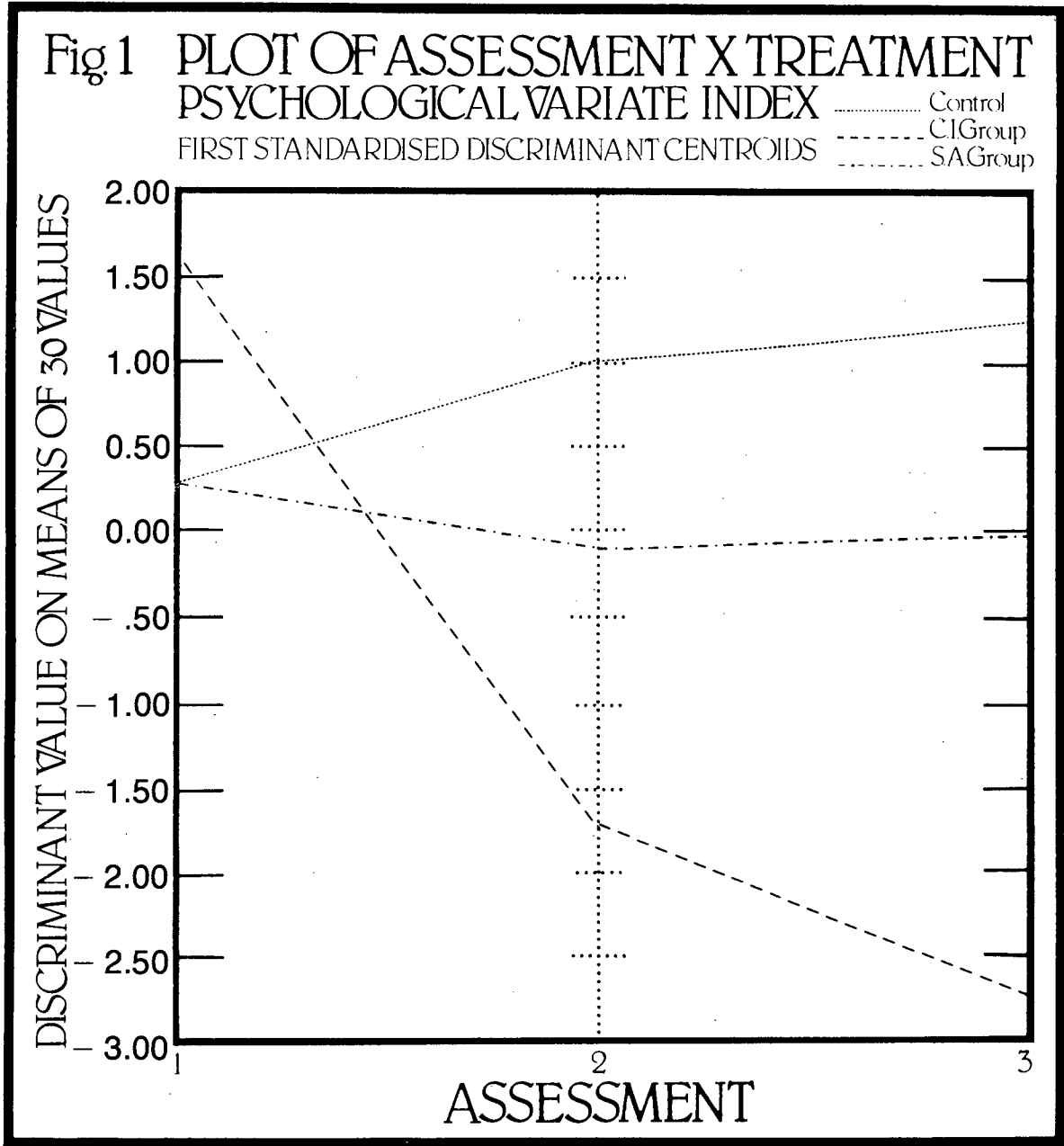


Fig. 2 PLOT OF ASSESSMENT X TREATMENT

VARIATE:SSCA SE-.0759

SIGNIFICANCE LEVEL-5%

..... Control
----- CI Group
----- SA Group

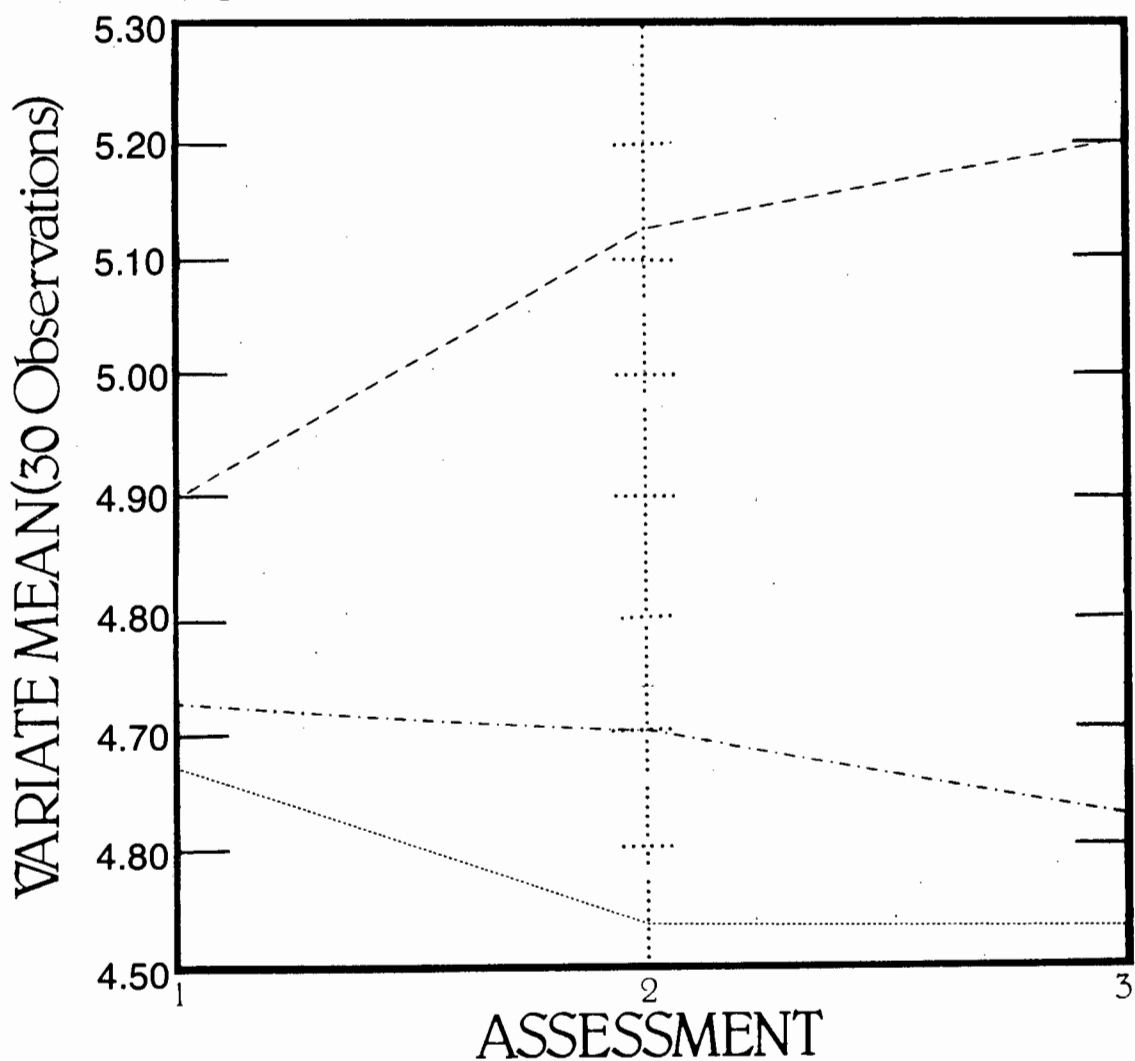


Fig. 3 PLOT OF ASSESSMENT X TREATMENT

VARIATE: SFAI SE: .0725
SIGNIFICANCE LEVEL: 5%

..... Control
----- CIGroup
----- SAGroup

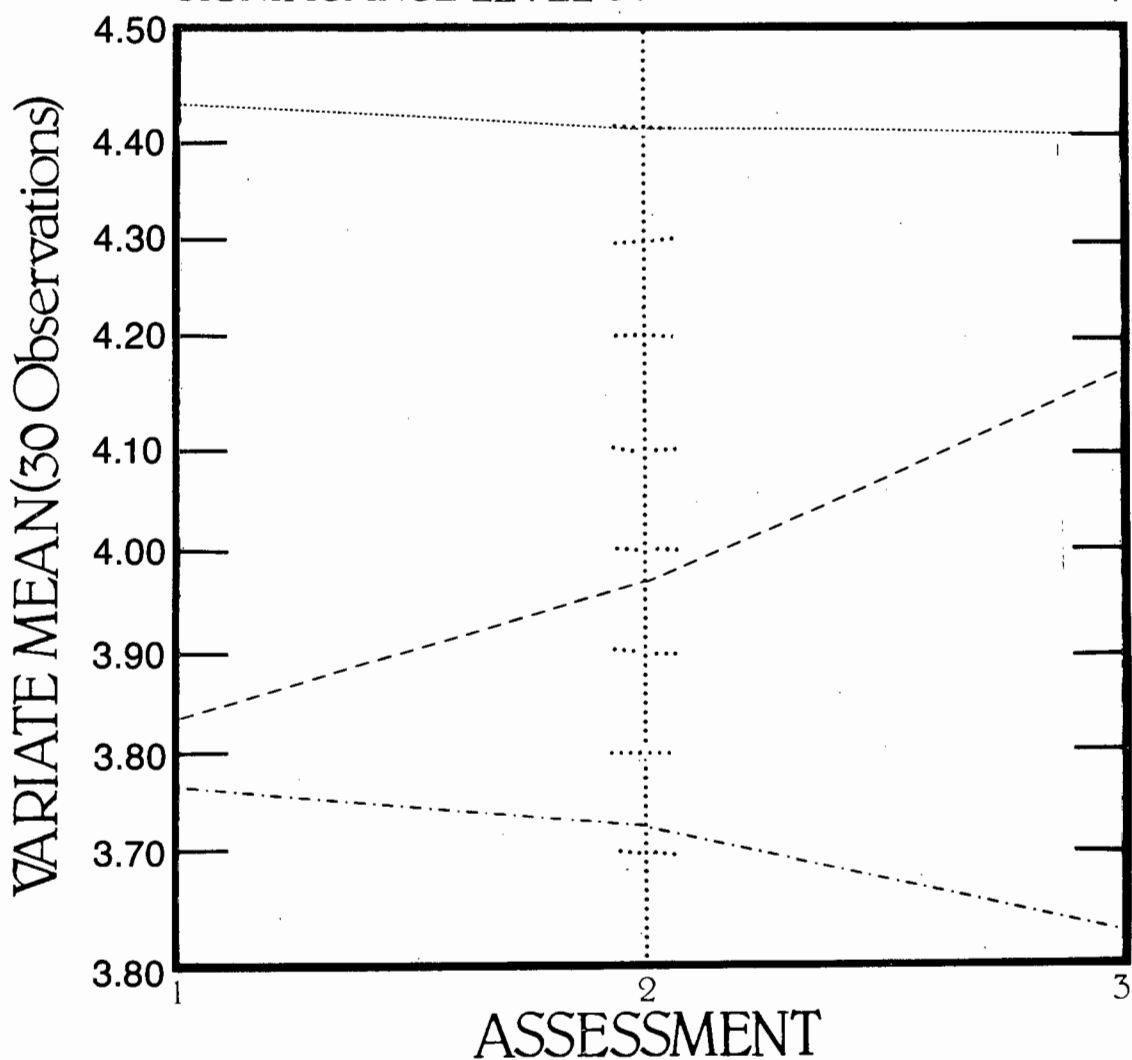


Fig. 4 PLOT OF ASSESSMENT X TREATMENT

VARIATE: SCOI S.E.: .0918
SIGNIFICANCE LEVEL: 5%

..... Control
----- C.I.Group
----- S.A.Group

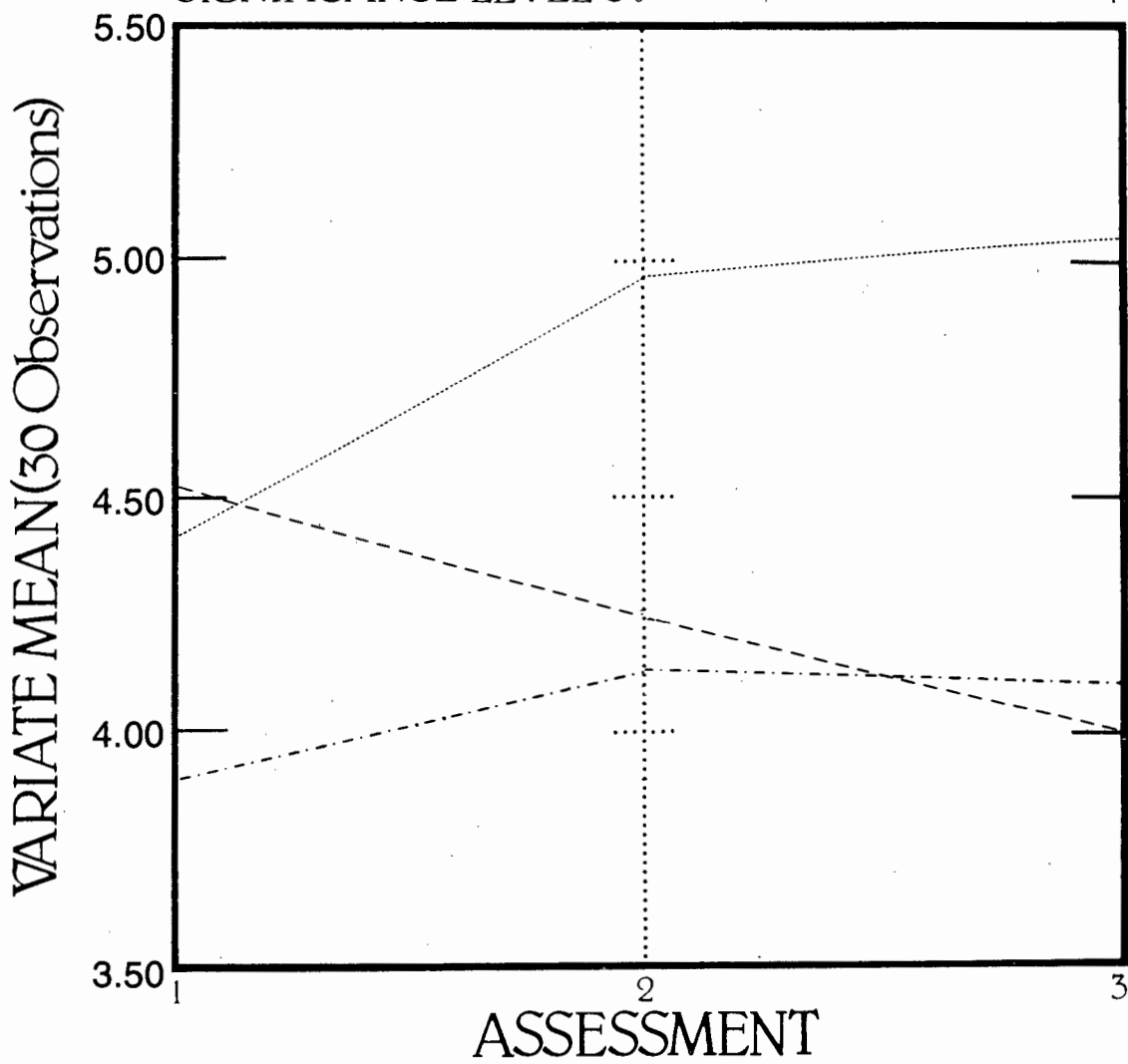


Fig.5 PLOT OF ASSESSMENT X TREATMENT

VARIATE:PBDE S.E.-.5268
SIGNIFICANCE LEVEL-5%

..... Control
----- CI Group
----- SA Group

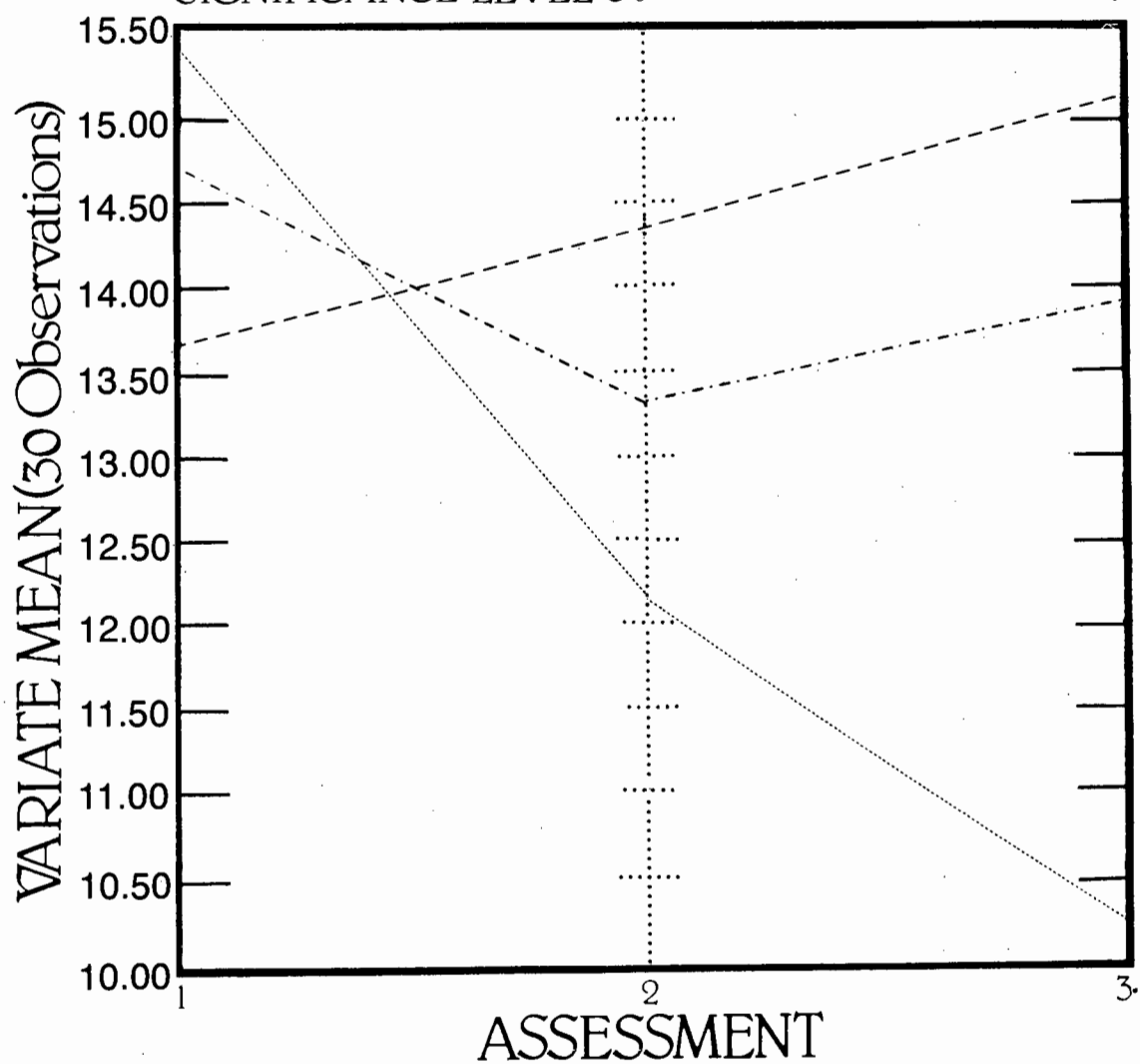


Fig.6 PLOT OF ASSESSMENT X TREATMENT

VARIATE-PLSA SE-414

SIGNIFICANCE LEVEL-5%

..... Control
----- C1Group
----- SAGroup

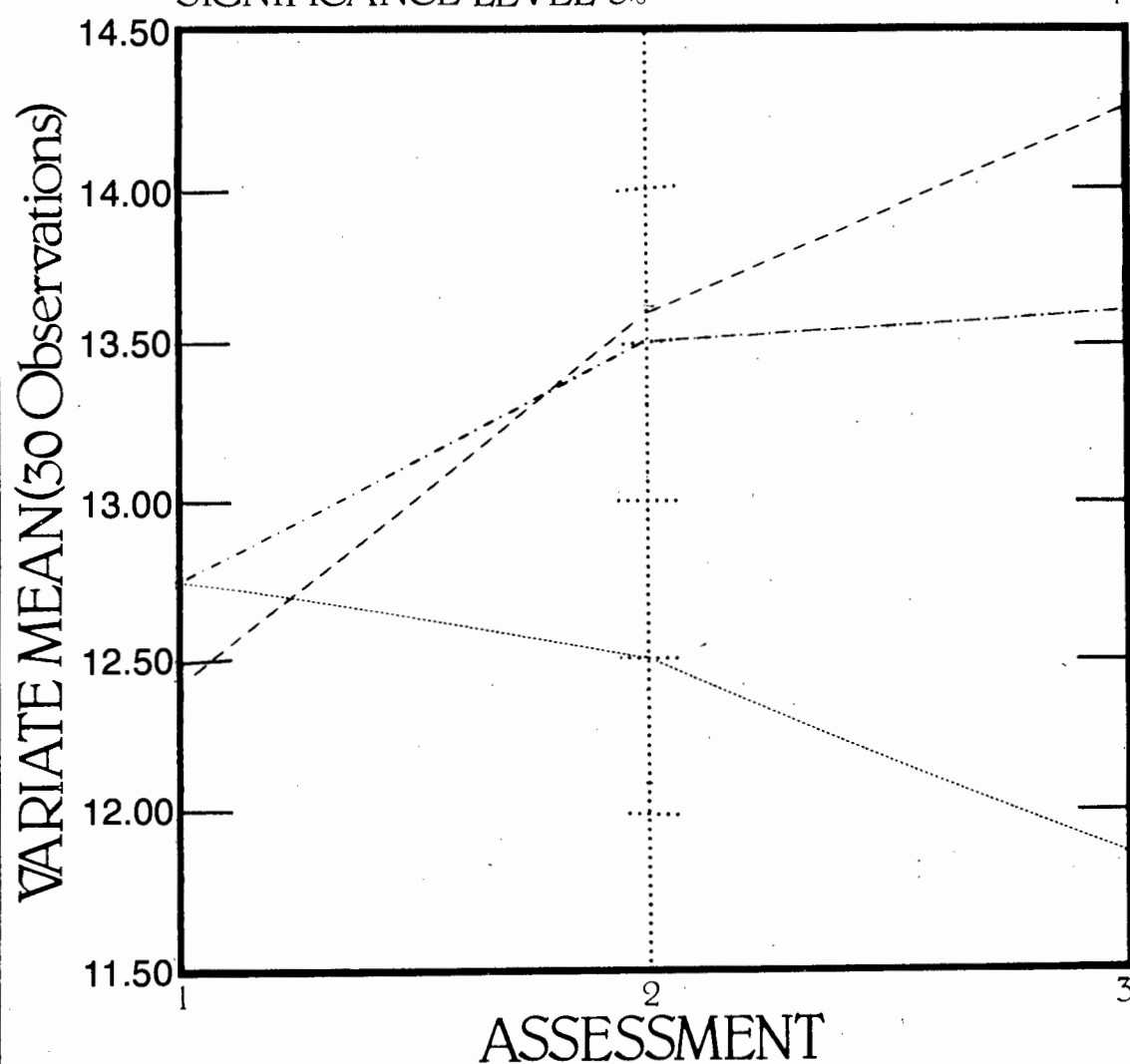


Fig 7 PLOT OF ASSESSMENT X TREATMENT

VARIATE-PSRA SE-.1372
SIGNIFICANCE LEVEL-5%

Control
CIGroup
SAGroup

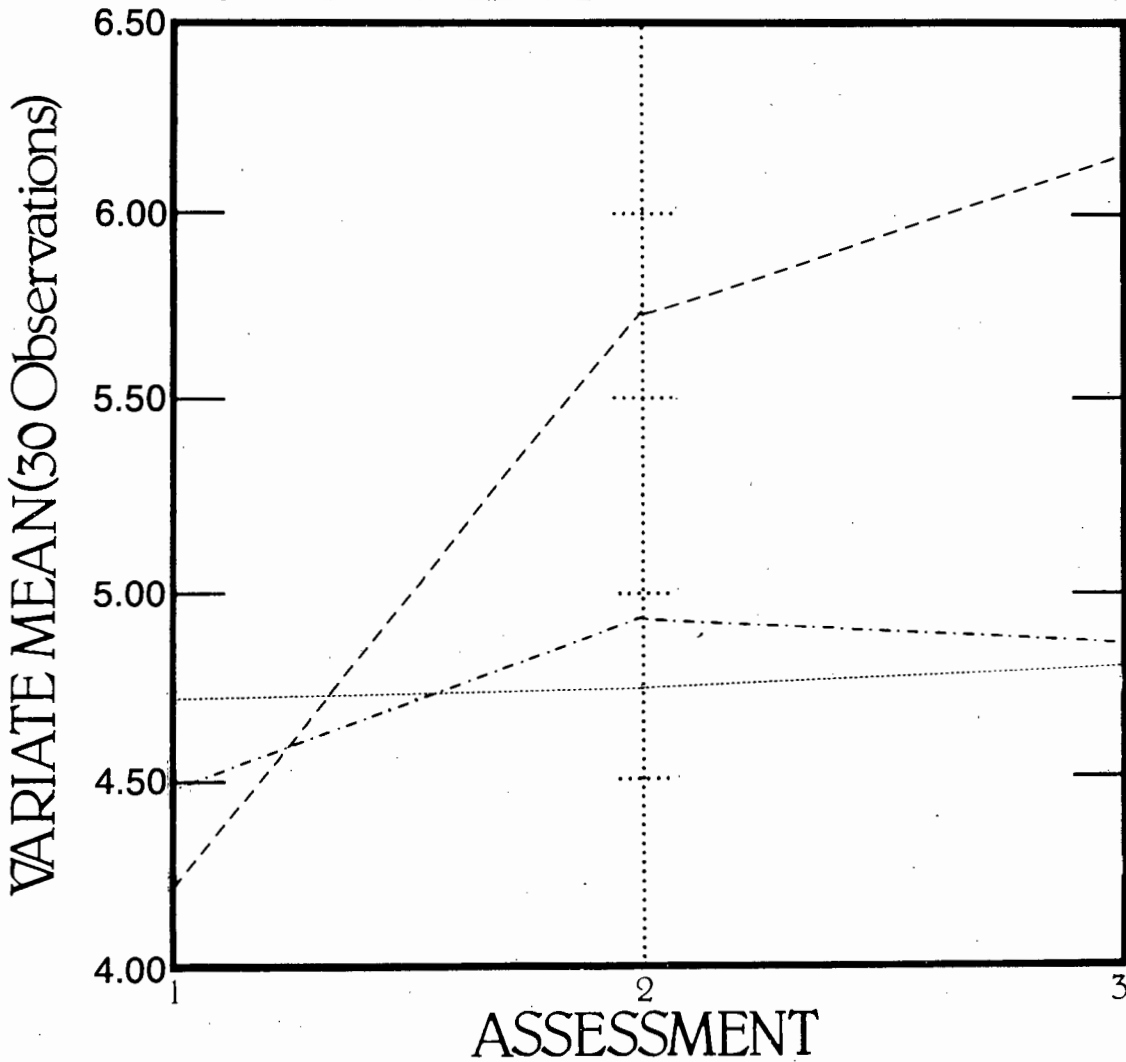


Fig 8 PLOT OF ASSESSMENT X TREATMENT

VARIATE: PRØ1 SE: .0758
SIGNIFICANCE LEVEL: 5%

Control
C1Group
SAGroup

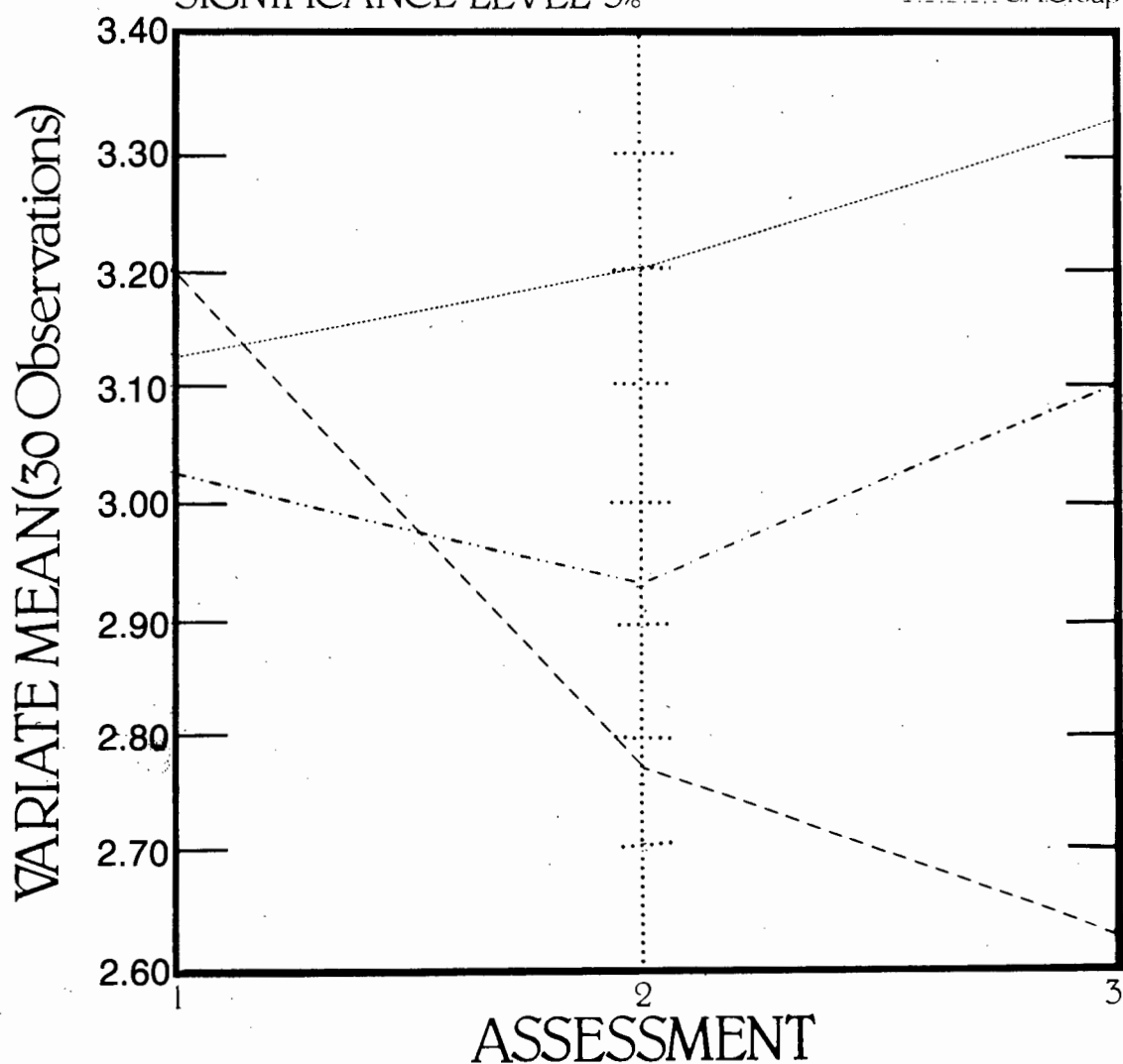


Fig.9 PLOT OF ASSESSMENT X TREATMENT

VARIATE: PRO2 SE: .1044
SIGNIFICANCE LEVEL: 5%

..... Control
- - - - - CIGroup
- SAGroup

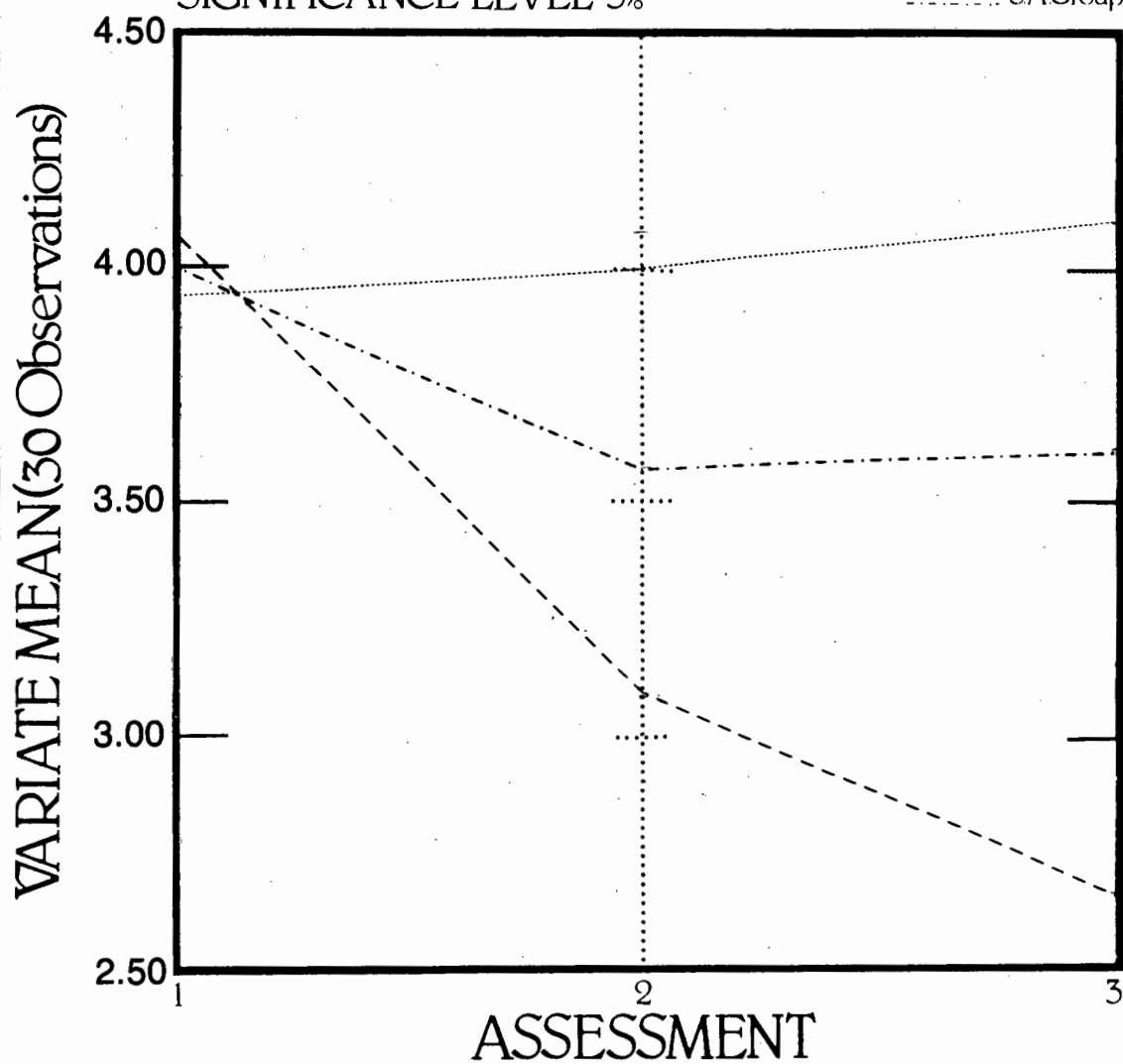


Fig.10 PLOT OF ASSESSMENT X TREATMENT

VARIATE: PRØ5 SE: .0821
SIGNIFICANCE LEVEL: 5%

Control
CIGroup
SAGroup

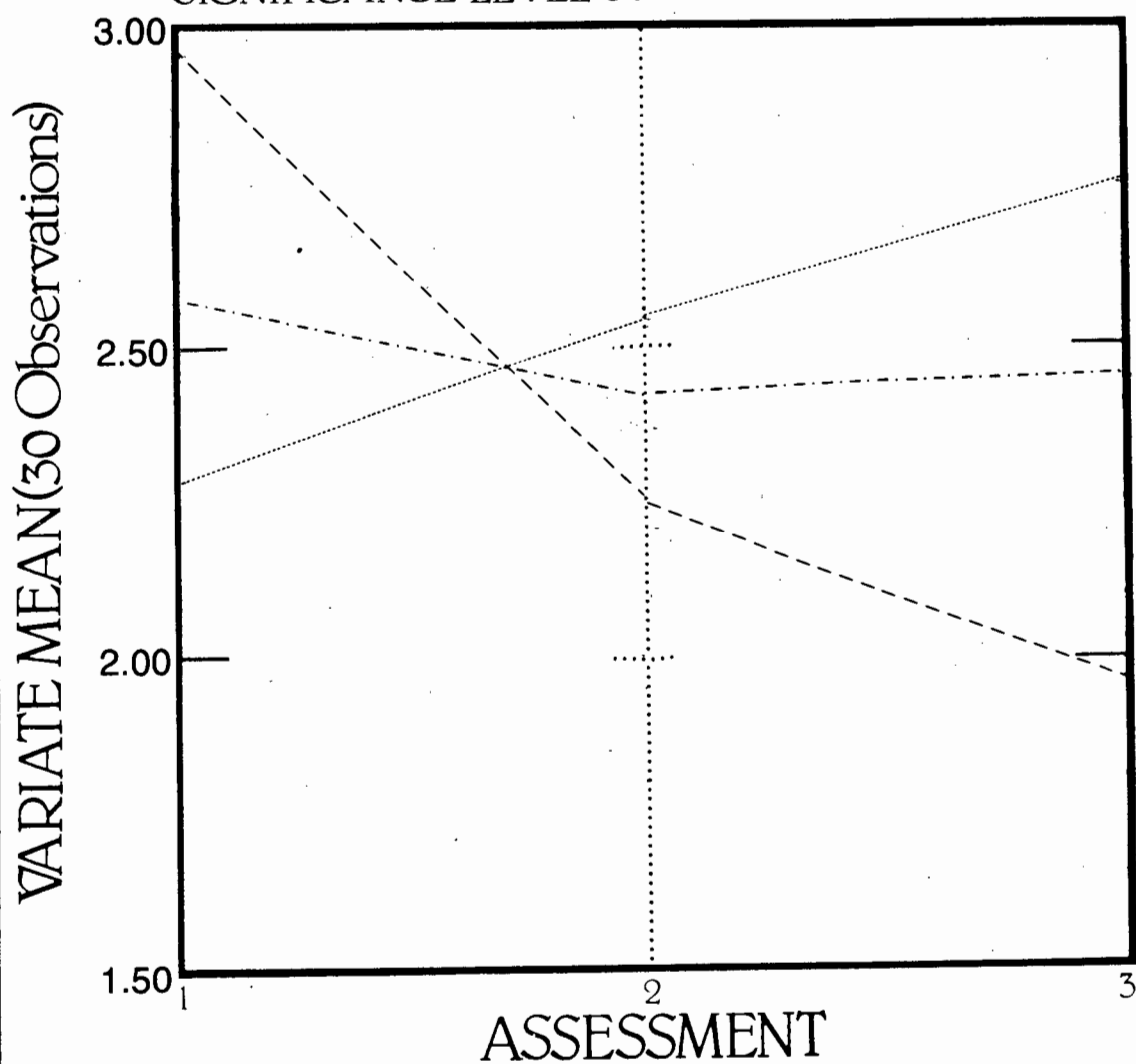


Fig.11 PLOT OF ASSESSMENT X TREATMENT

VARIATE-PRØ6 SE-.0758
SIGNIFICANCE LEVEL-5%

..... Control
----- CI Group
----- SA Group

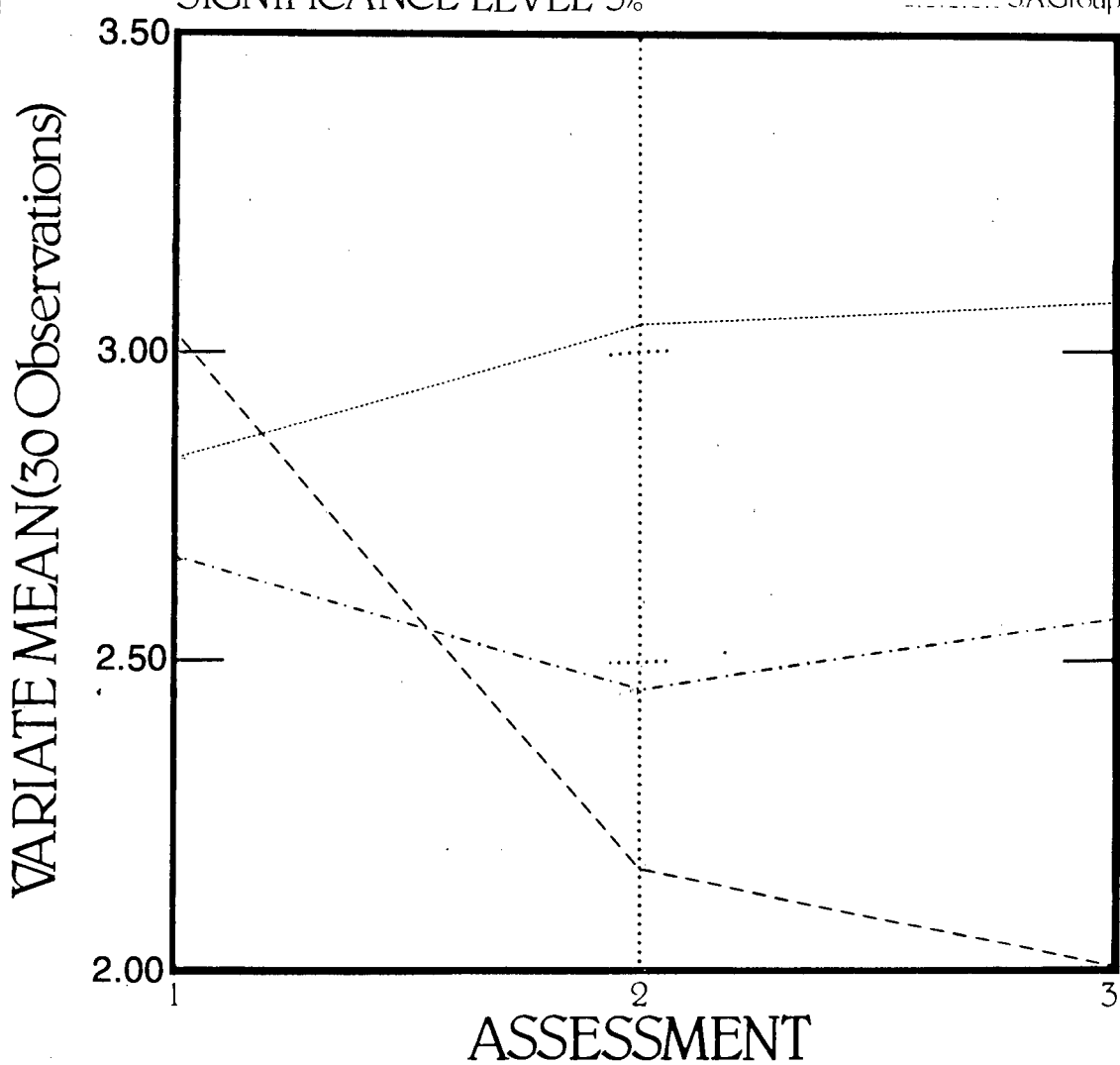


Fig.12 PLOT OF ASSESSMENT X TREATMENT

VARIATE: PRØ9 SE: .1241
SIGNIFICANCE LEVEL: 5%

..... Control
- - - - - C.I.Group
- S.A.Group

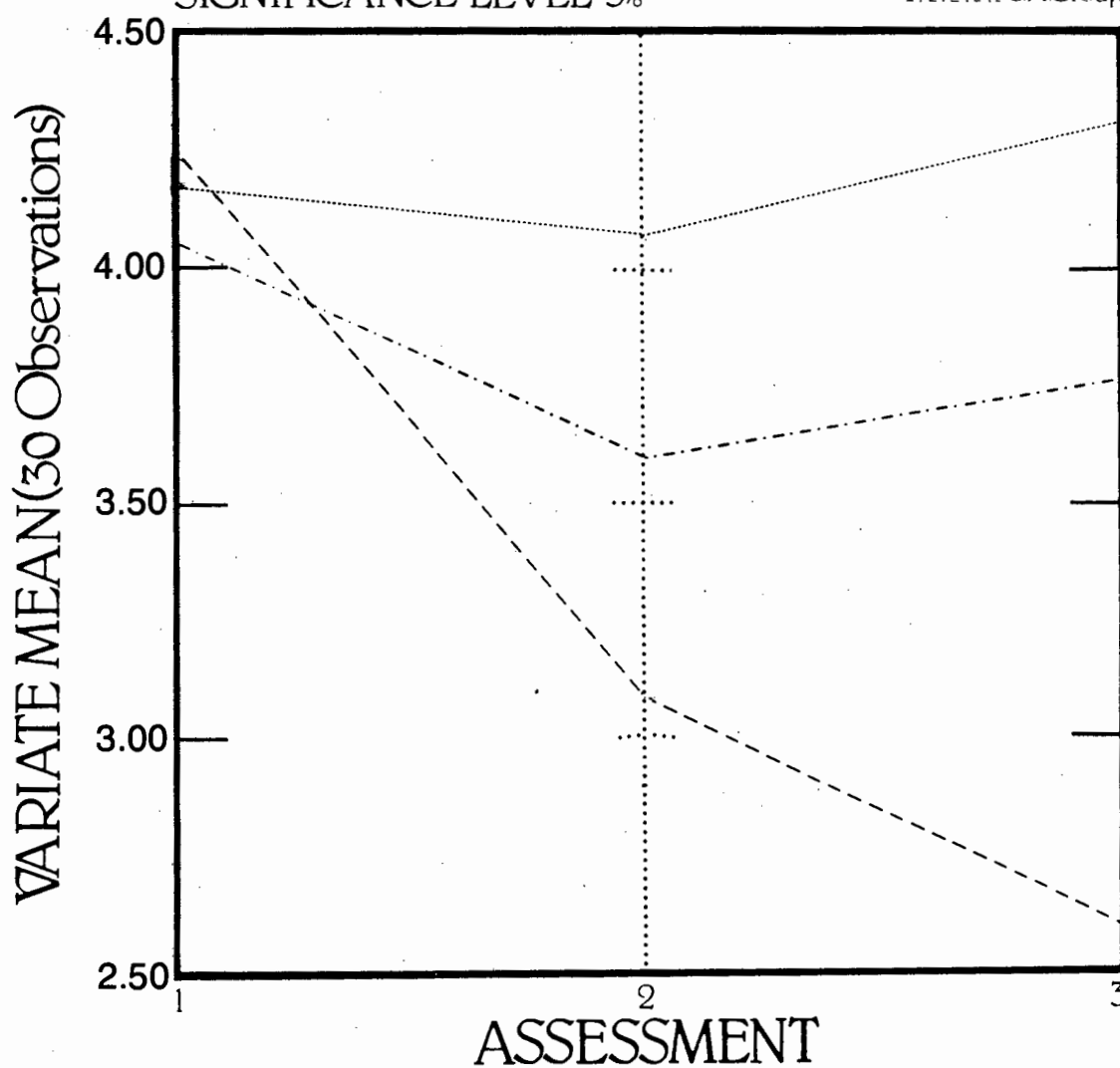


Fig.13 PLOT OF ASSESSMENT X TREATMENT

VARIATE-PR10 SE-.1091
SIGNIFICANCE LEVEL-5%

..... Control
----- C.I.Group
----- SAGroup

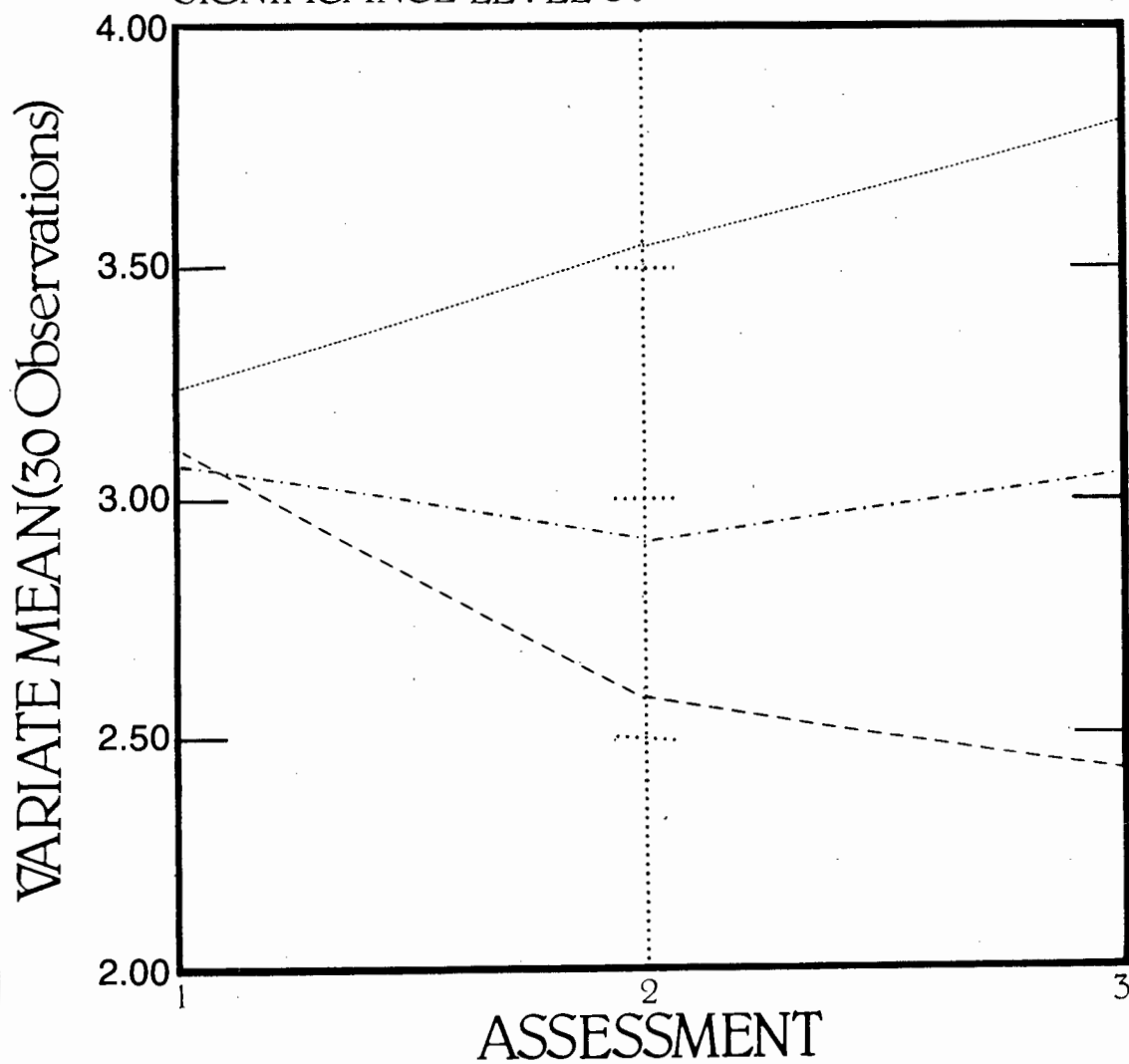


Fig.14 PLOT OF ASSESSMENT X TREATMENT

VARIATE:PR11 SE-.0889
SIGNIFICANCE LEVEL-5%

..... Control
- - - - - C.I.Group
..... S.A.Group

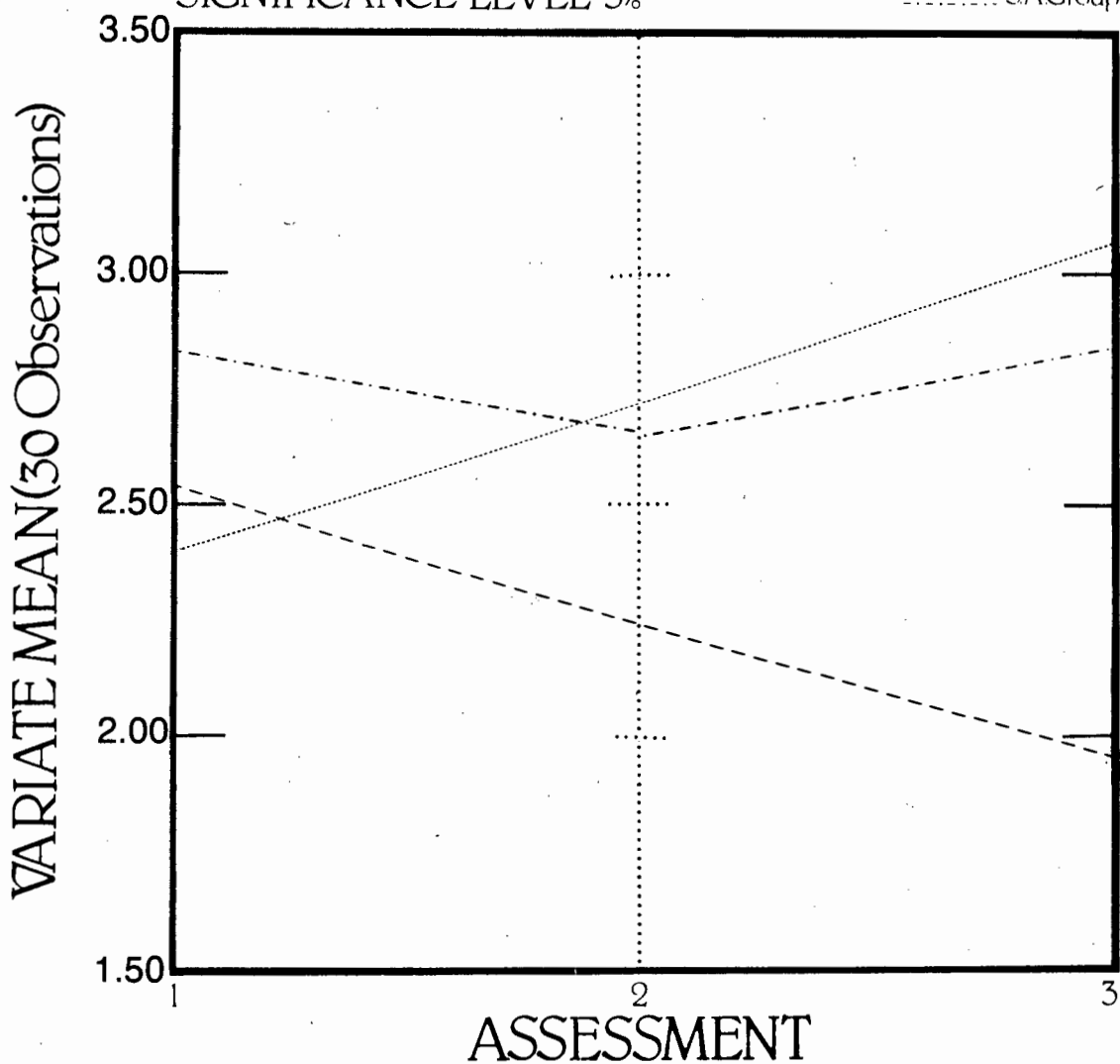


Fig15 PLOT OF ASSESSMENT X TREATMENT

VARIATE: PR13 SE: .0797
SIGNIFICANCE LEVEL: 5%

..... Control
----- CI Group
----- SA Group

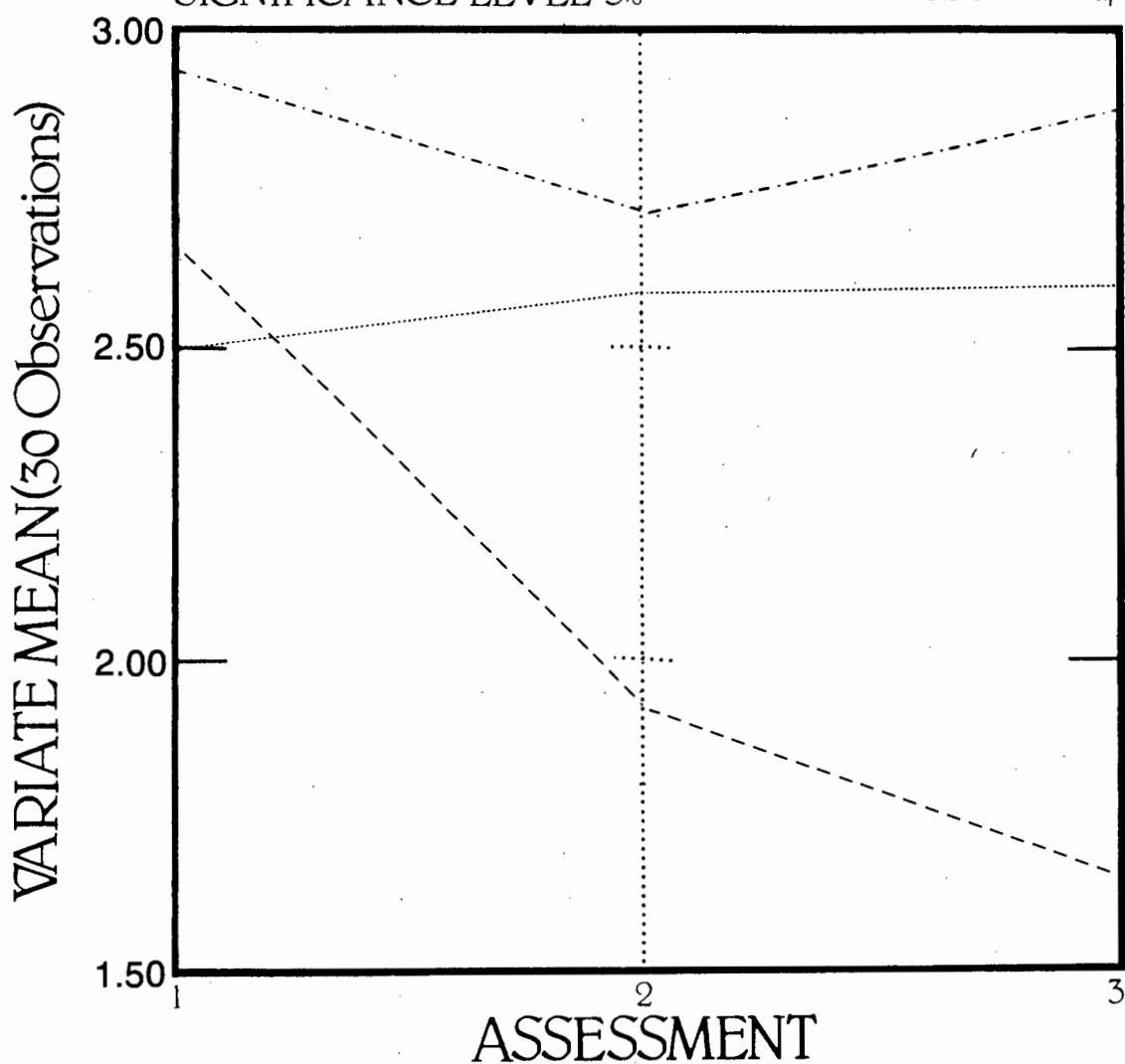


Fig.16 PLOT OF ASSESSMENT X TREATMENT

VARIATE:PR14 SE: .0639
SIGNIFICANCE LEVEL-5%

..... Control
- - - - - C.I.Group
- - - - - S.A.Group

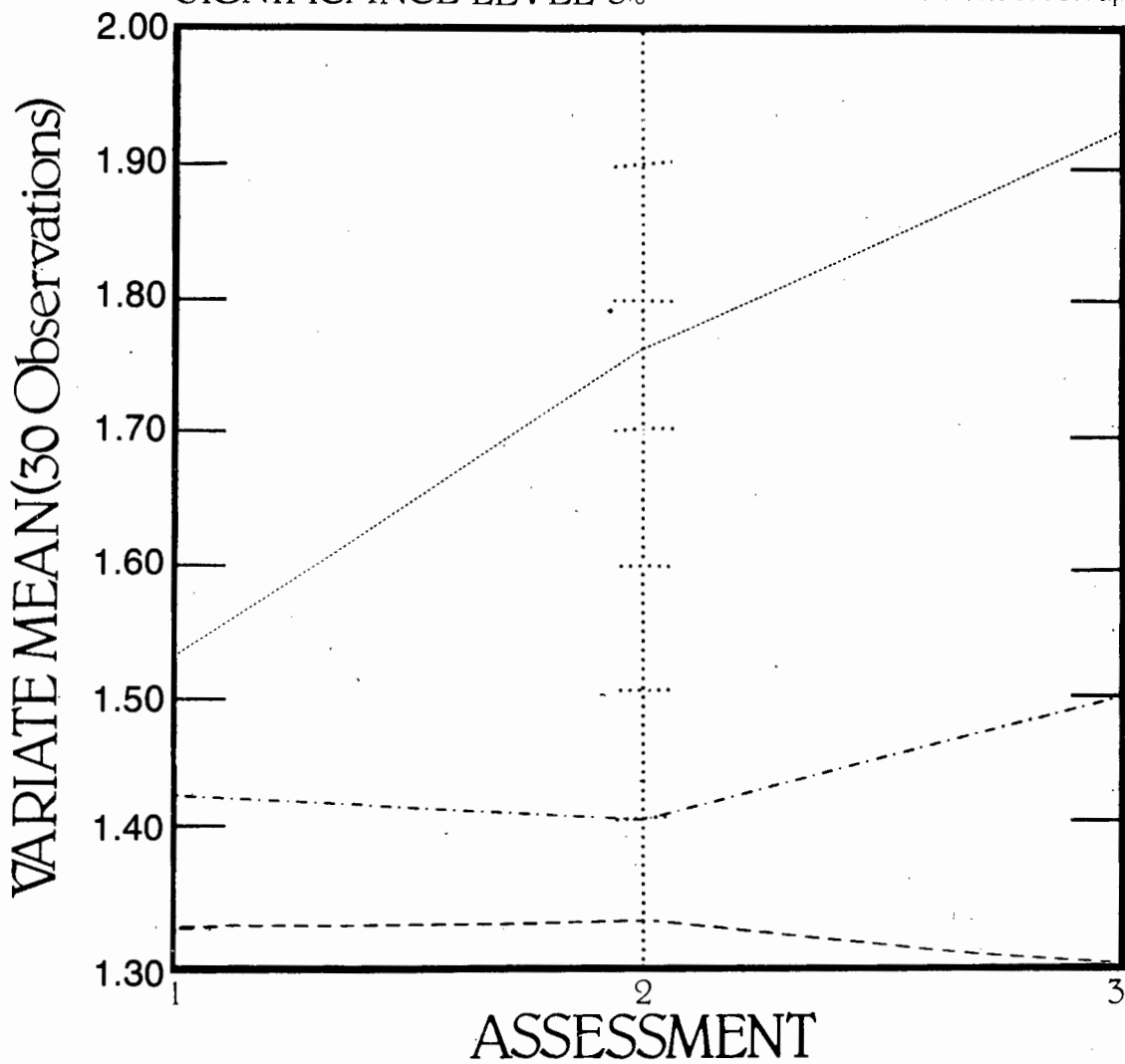


Fig.17 PLOT OF ASSESSMENT X TREATMENT

VARIATE-PR15 SE-.0575
SIGNIFICANCE LEVEL-5%

..... Control
----- C.I.Group
..... SAGroup

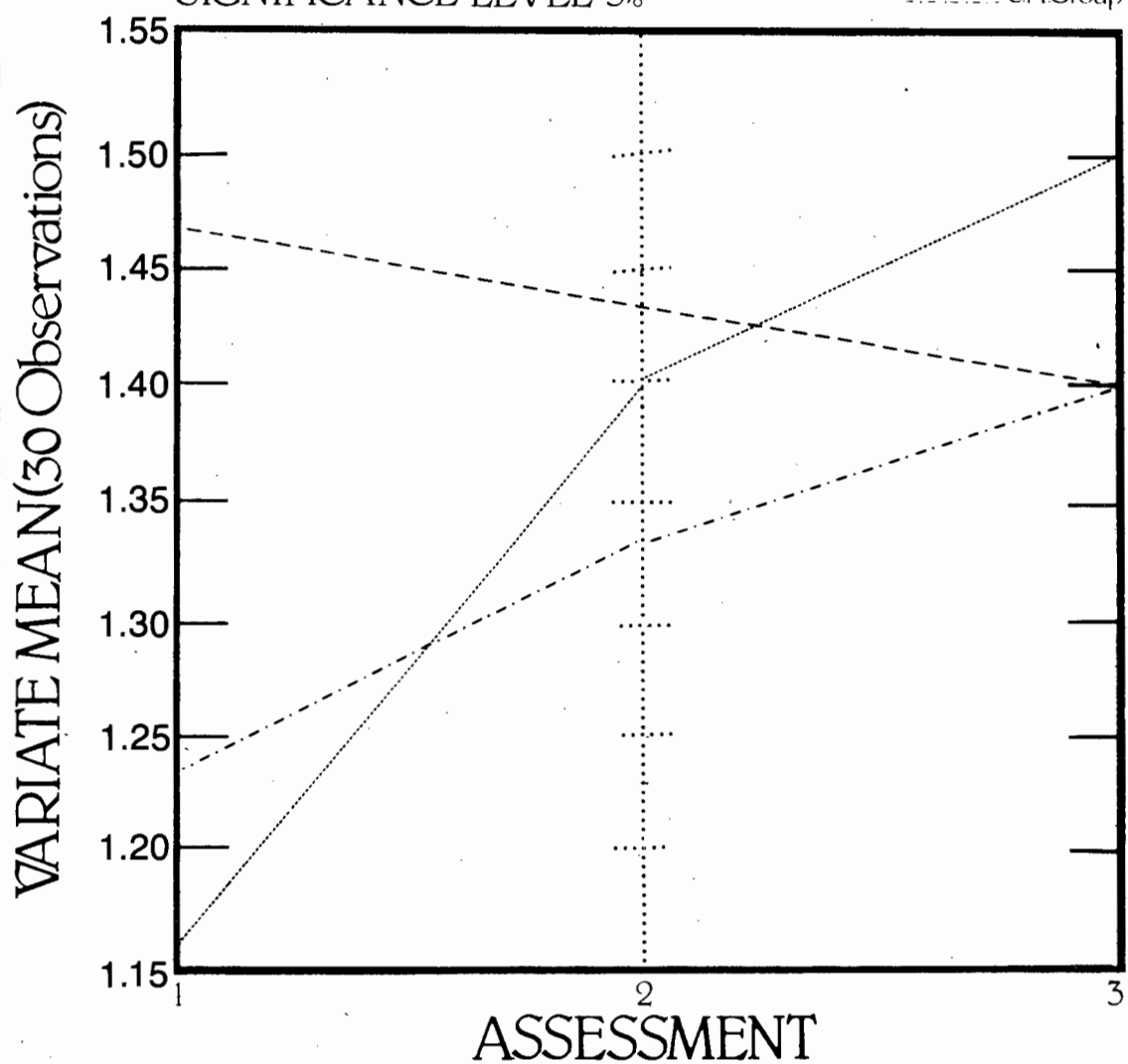


Fig18 PLOT OF ASSESSMENT X TREATMENT

VARIATE: PR16 SE: .0918
SIGNIFICANCE LEVEL: 5%

Control
CIGroup
SAGroup

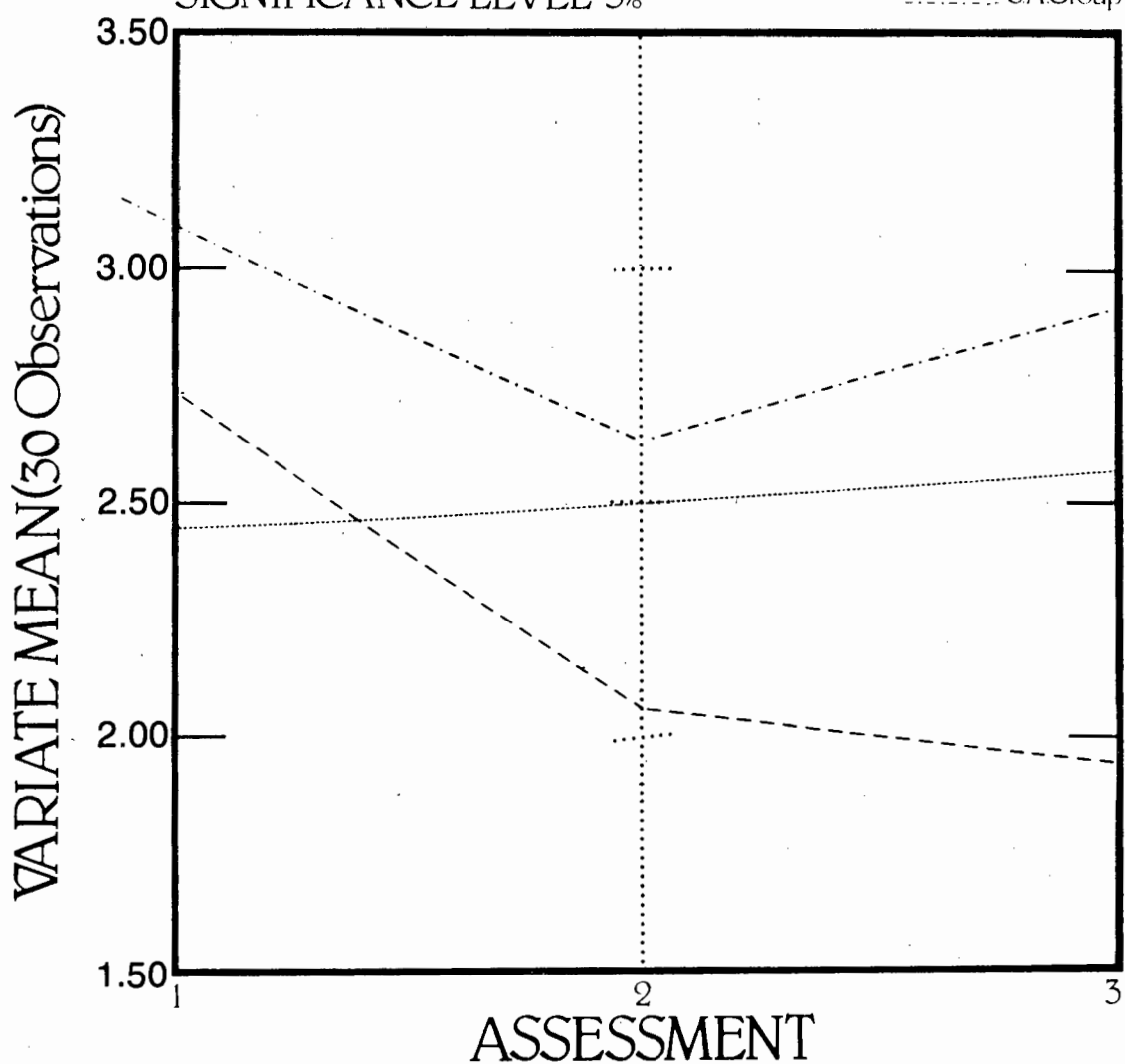


Fig.19 PLOT OF ASSESSMENT X TREATMENT

VARIATE-PR17 SE-.084
SIGNIFICANCE LEVEL-5%

..... Control
----- C.I.Group
..... SAGroup

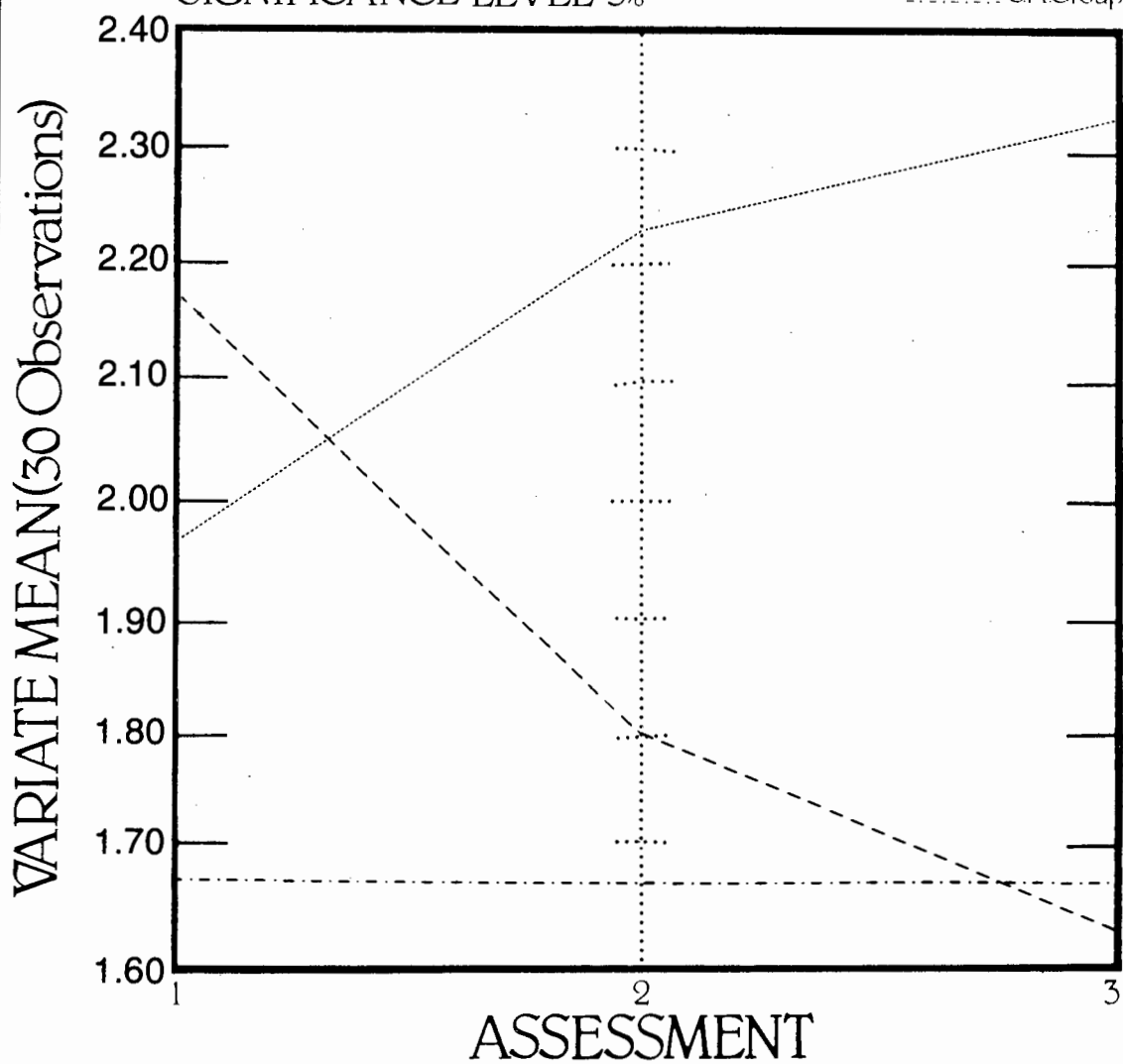


Fig.20 PLOT OF ASSESSMENT X TREATMENT

VARIATE: POSE S.E.: .3538

SIGNIFICANCE LEVEL: 5%

..... Control
----- CIGroup
----- SAGroup

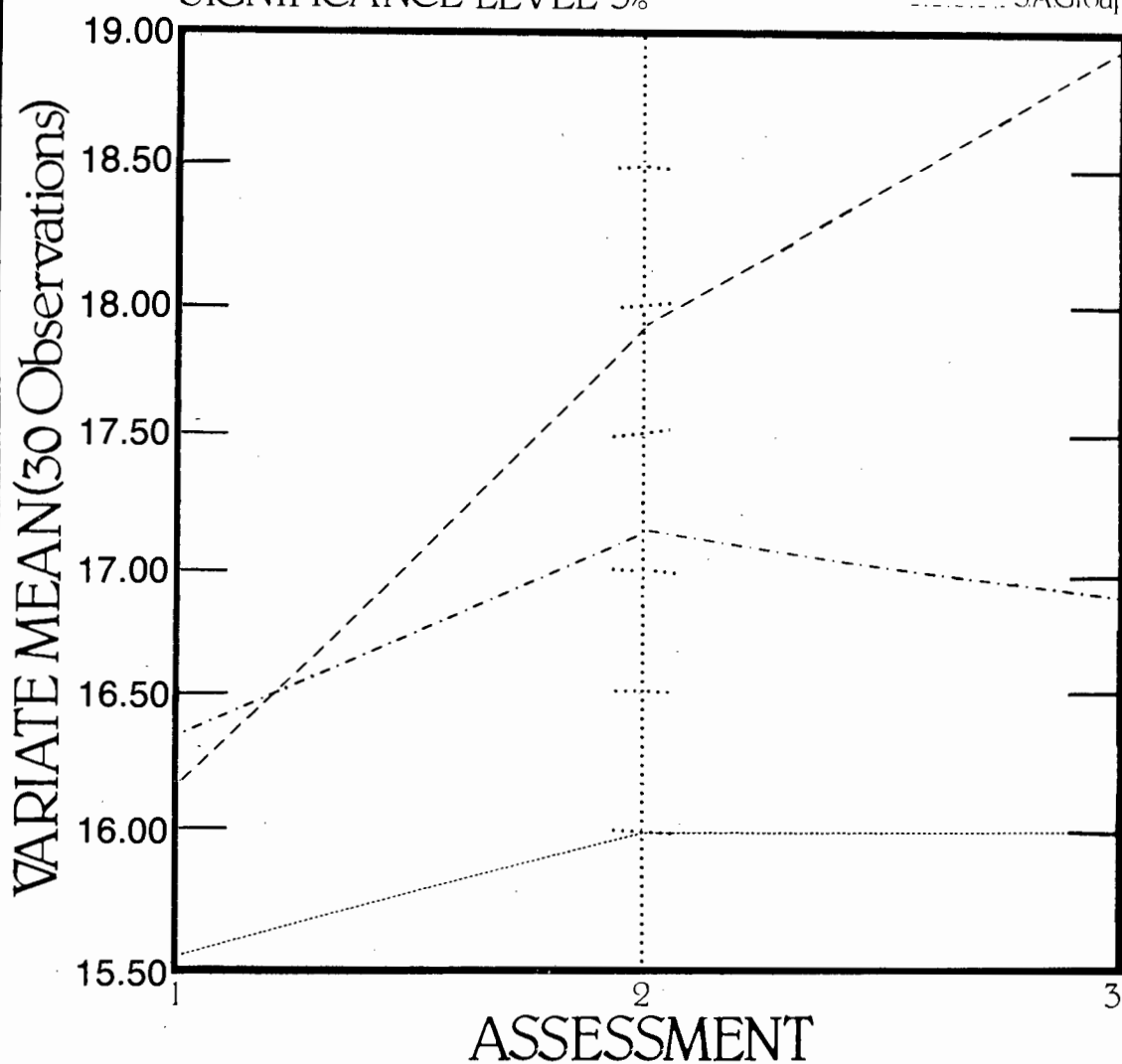


Fig 21 PLOT OF ASSESSMENT X TREATMENT

VARIATE-PIB1 SE-.0814
SIGNIFICANCE LEVEL-1%

Control
C1Group
SAGroup

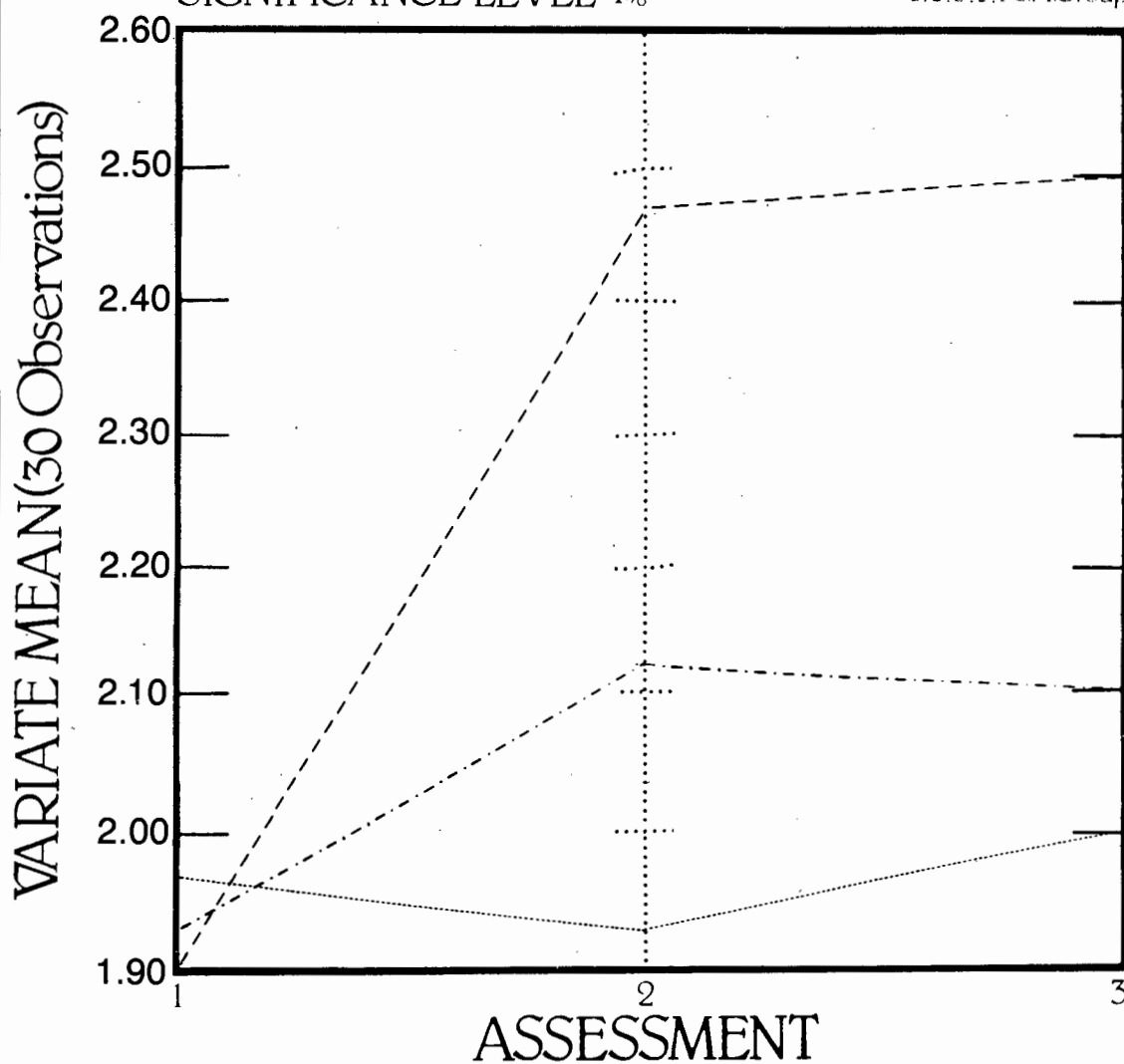


Fig.22 PLOT OF ASSESSMENT X TREATMENT

VARIATE: PIB2 SE-.0927

SIGNIFICANCE LEVEL-5%

Control
CIGroup
SAGroup

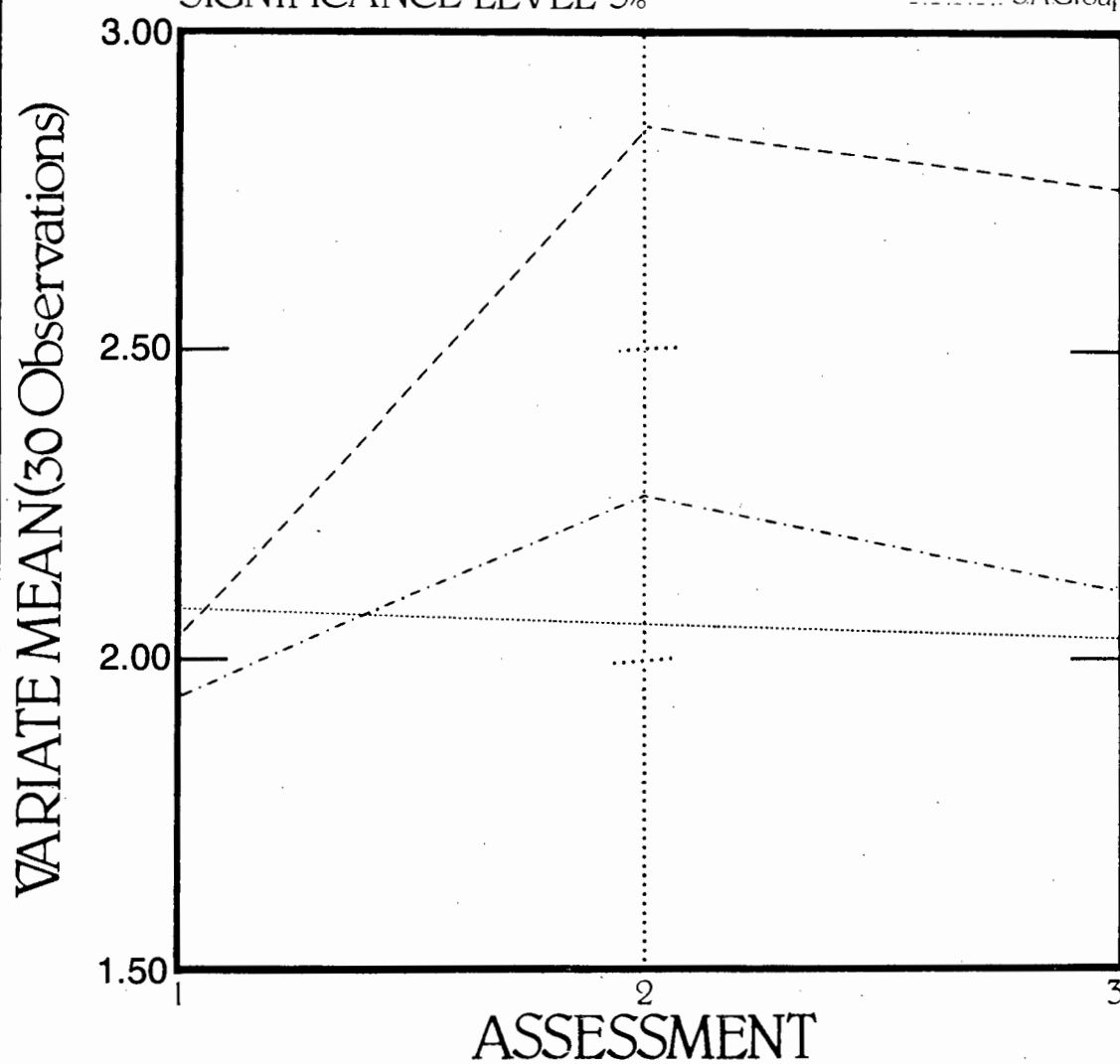


Fig.23 PLOT OF ASSESSMENT X TREATMENT

VARIATE:PIB3 SE-.0858

SIGNIFICANCE LEVEL-5%

..... Control
----- CI Group
----- SAGroup

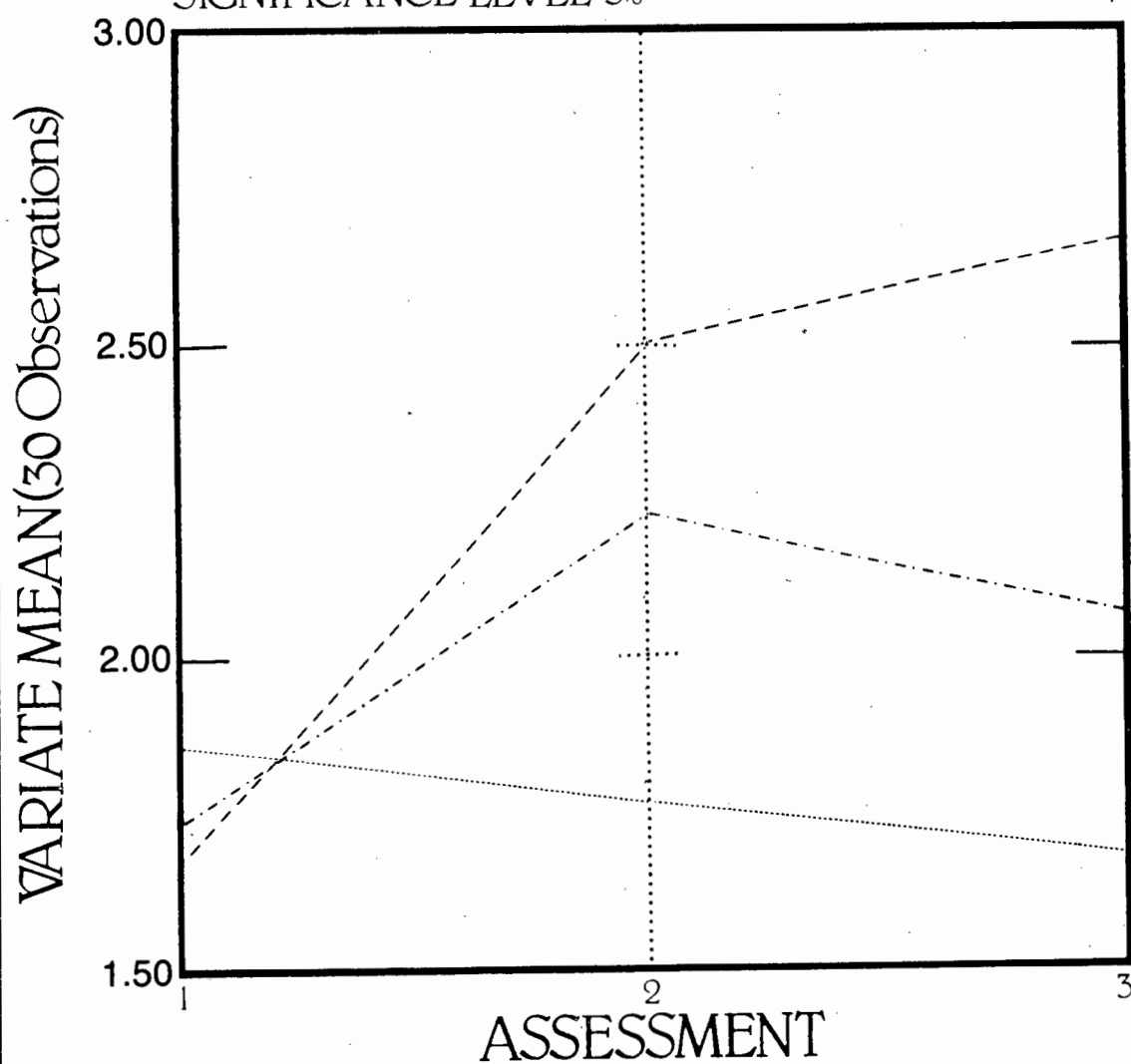


Fig 24 PLOT OF ASSESSMENT X TREATMENT

VARIATE-PIB4 SE-.0918
SIGNIFICANCE LEVEL-5%

..... Control
- - - - - CIGroup
- - - - - SAGroup

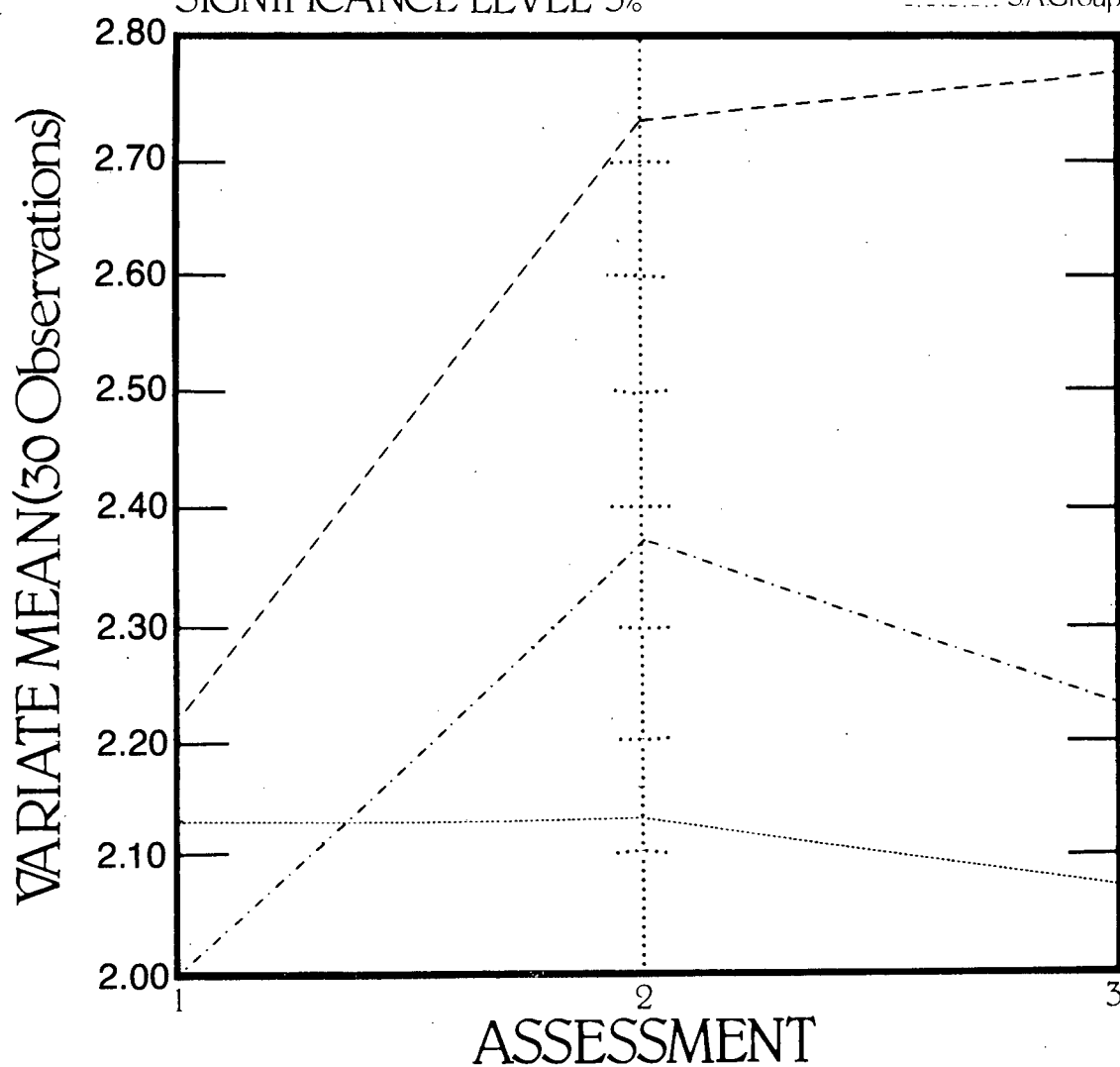


Fig25 PLOT OF ASSESSMENT X TREATMENT

VARIATE- PIB5 SE-.0803
SIGNIFICANCE LEVEL-5%

..... Control
- - - - - CIGroup
- - - - - SAGroup

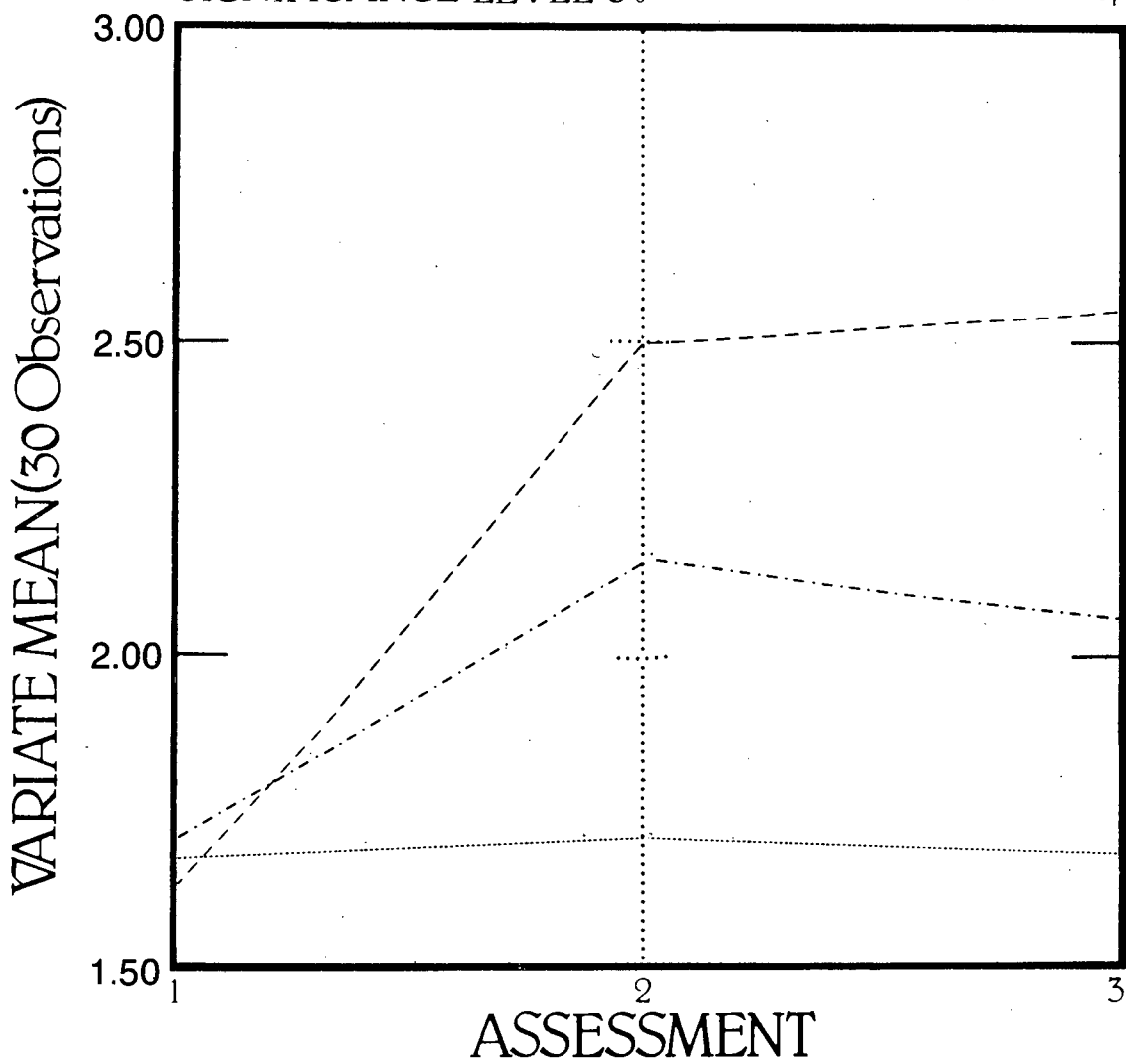


Fig 26 PLOT OF ASSESSMENT X TREATMENT

VARIATE-PSAC SE-.2664
SIGNIFICANCE LEVEL-5%

..... Control
----- CIGroup
..... SAGroup

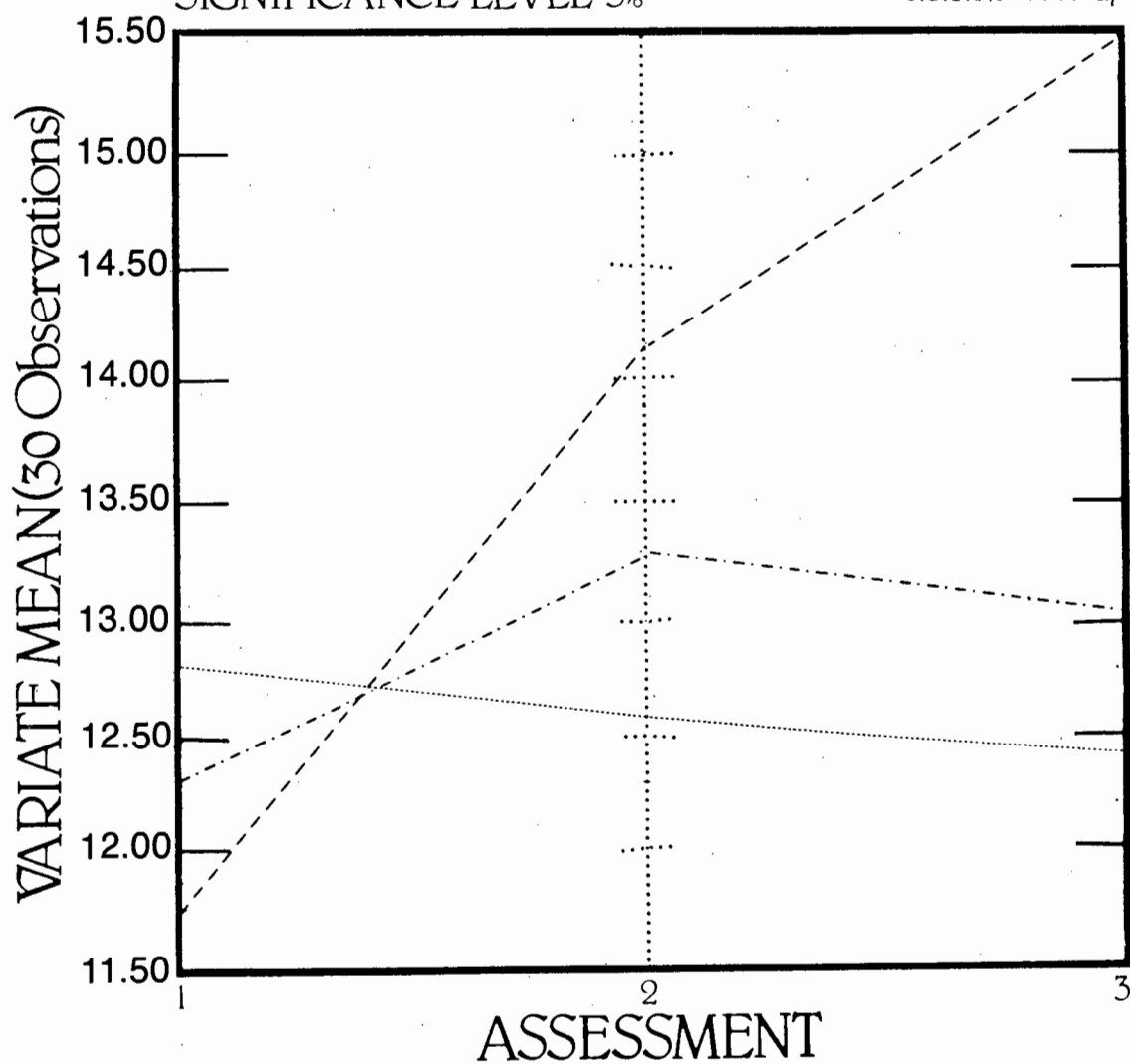


Fig.27 PLOT OF ASSESSMENT X TREATMENT

VARIATE-PPM1 S.E-.1295
SIGNIFICANCE LEVEL-5%

..... Control
----- C1Group
----- SAGroup

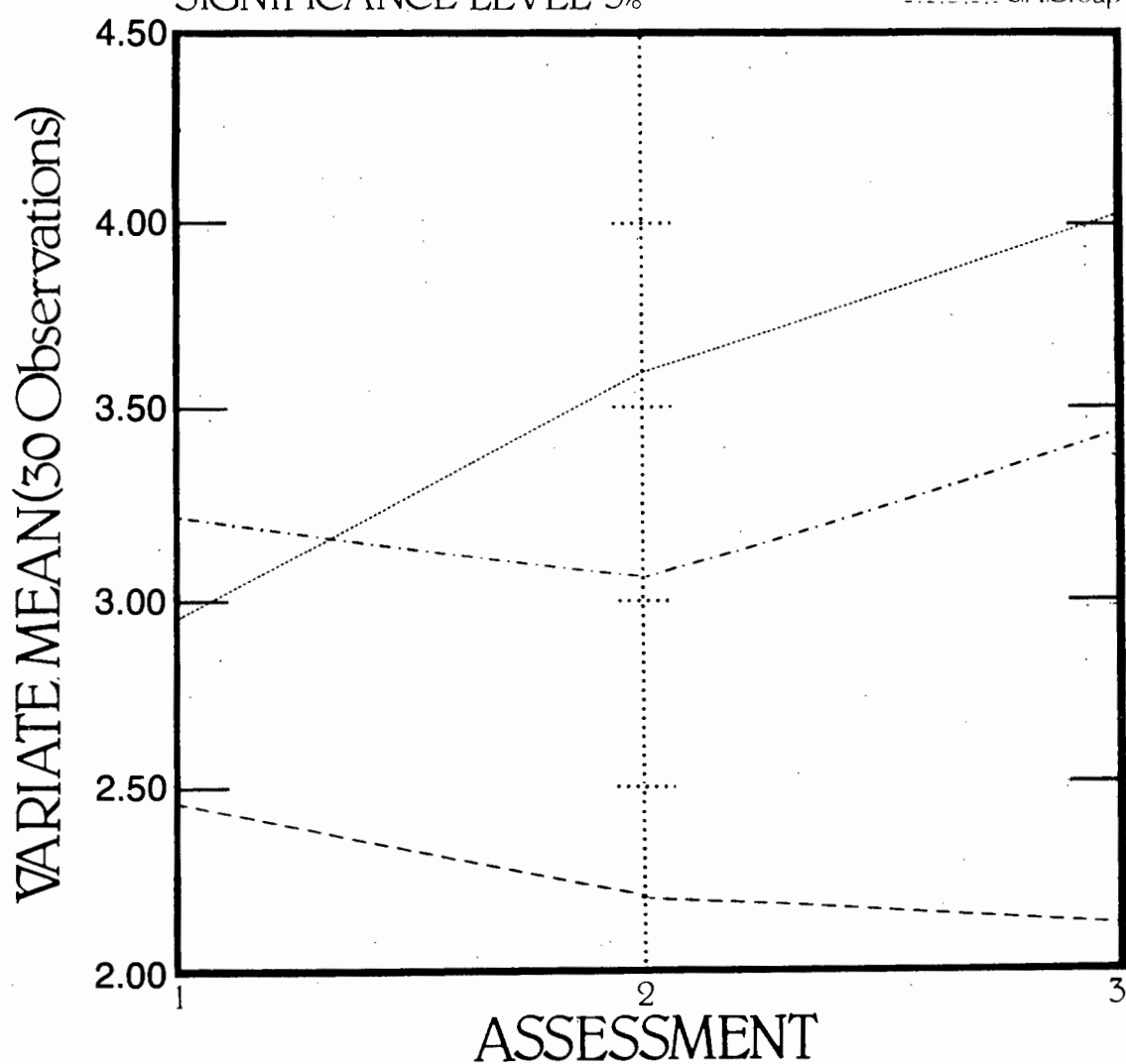


Fig.28 PLOT OF ASSESSMENT X TREATMENT

VARIATE-PPM2 SE-.0667
SIGNIFICANCE LEVEL-5%

..... Control
----- C.I.Group
----- SAGroup

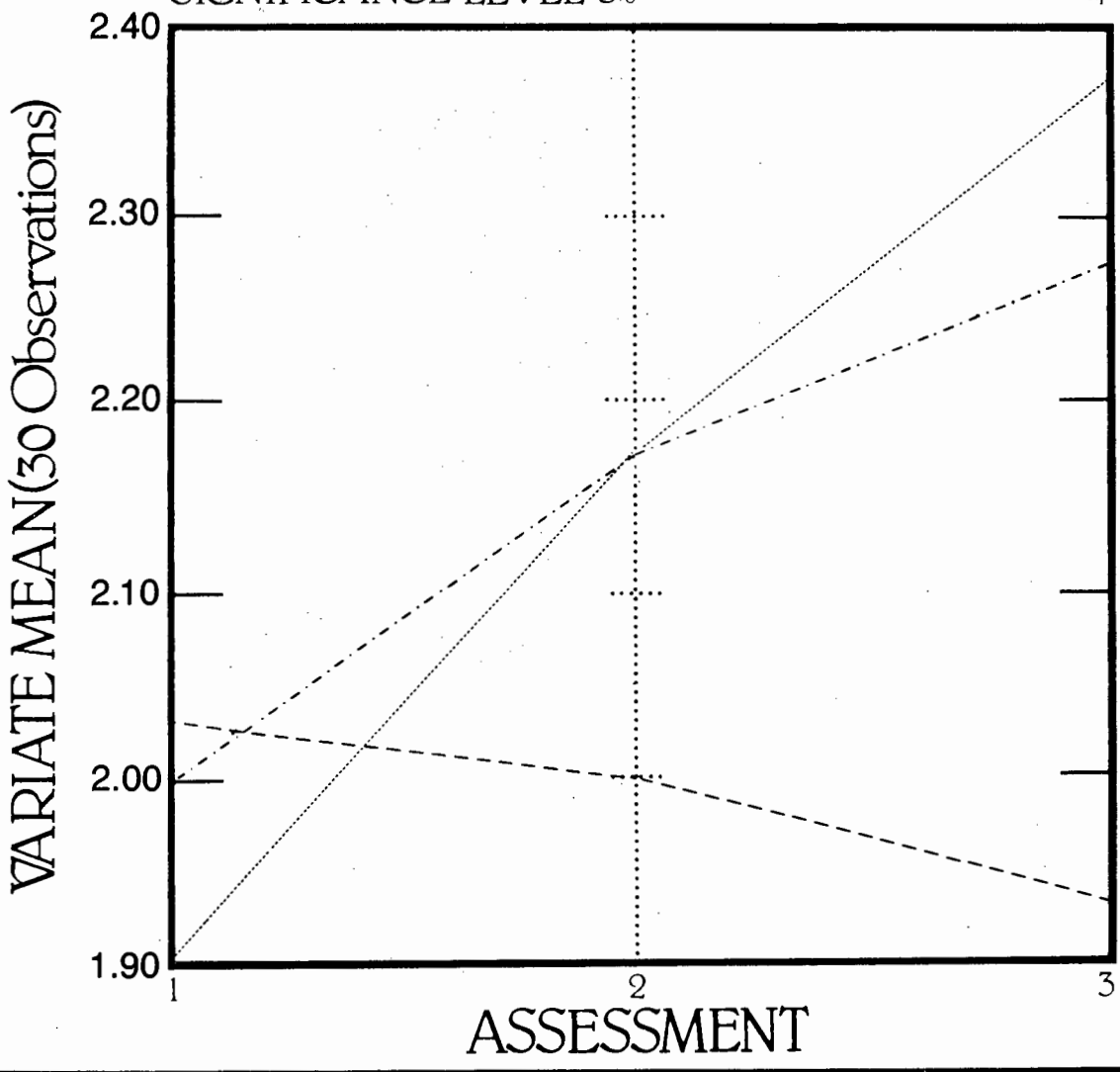


Fig29 PLOT OF ASSESSMENT X TREATMENT

VARIATE:PPM3 S.E-.1036

SIGNIFICANCE LEVEL-5%

..... Control
----- C1Group
----- SAGroup

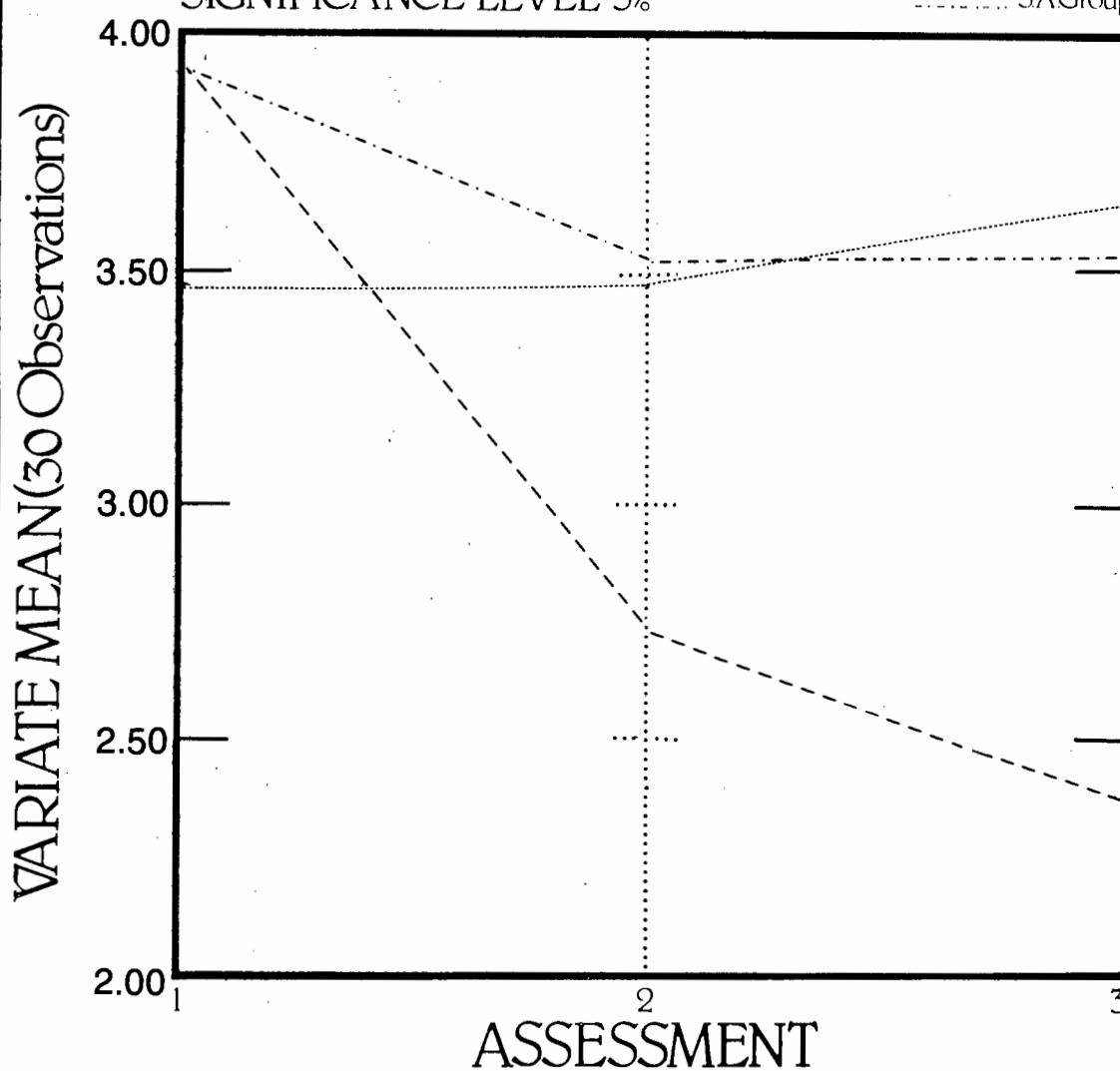


Fig.30 PLOT OF ASSESSMENT X TREATMENT

VARIATE:PPM5 SE-.0726
SIGNIFICANCE LEVEL-5%

Control
CIGroup
SAGroup

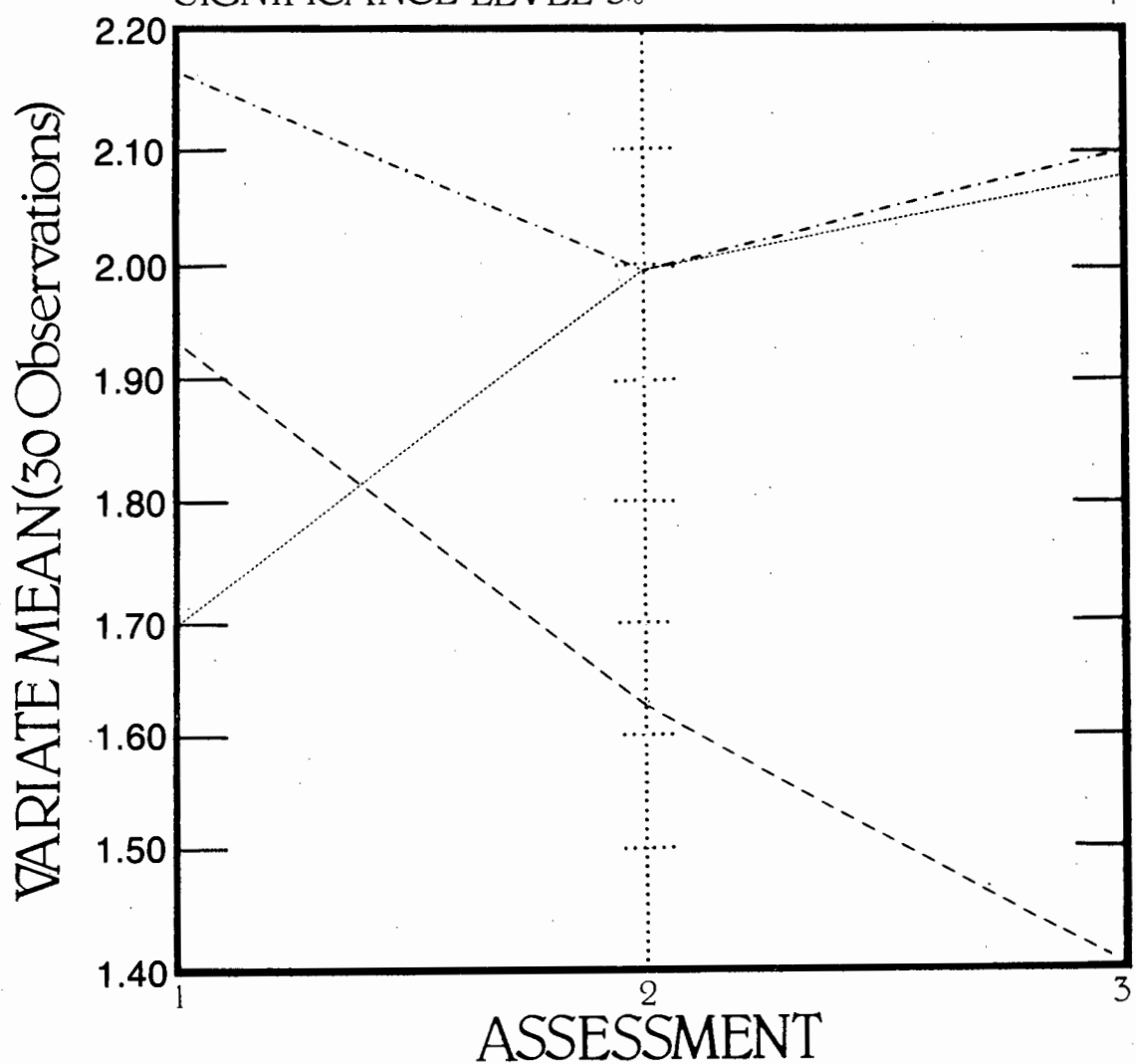


Fig.31 PLOT OF ASSESSMENT X TREATMENT

VARIATE-PPM6 S.E. .0812
SIGNIFICANCE LEVEL-5%

.....Control
-----CI Group
-----SAGroup

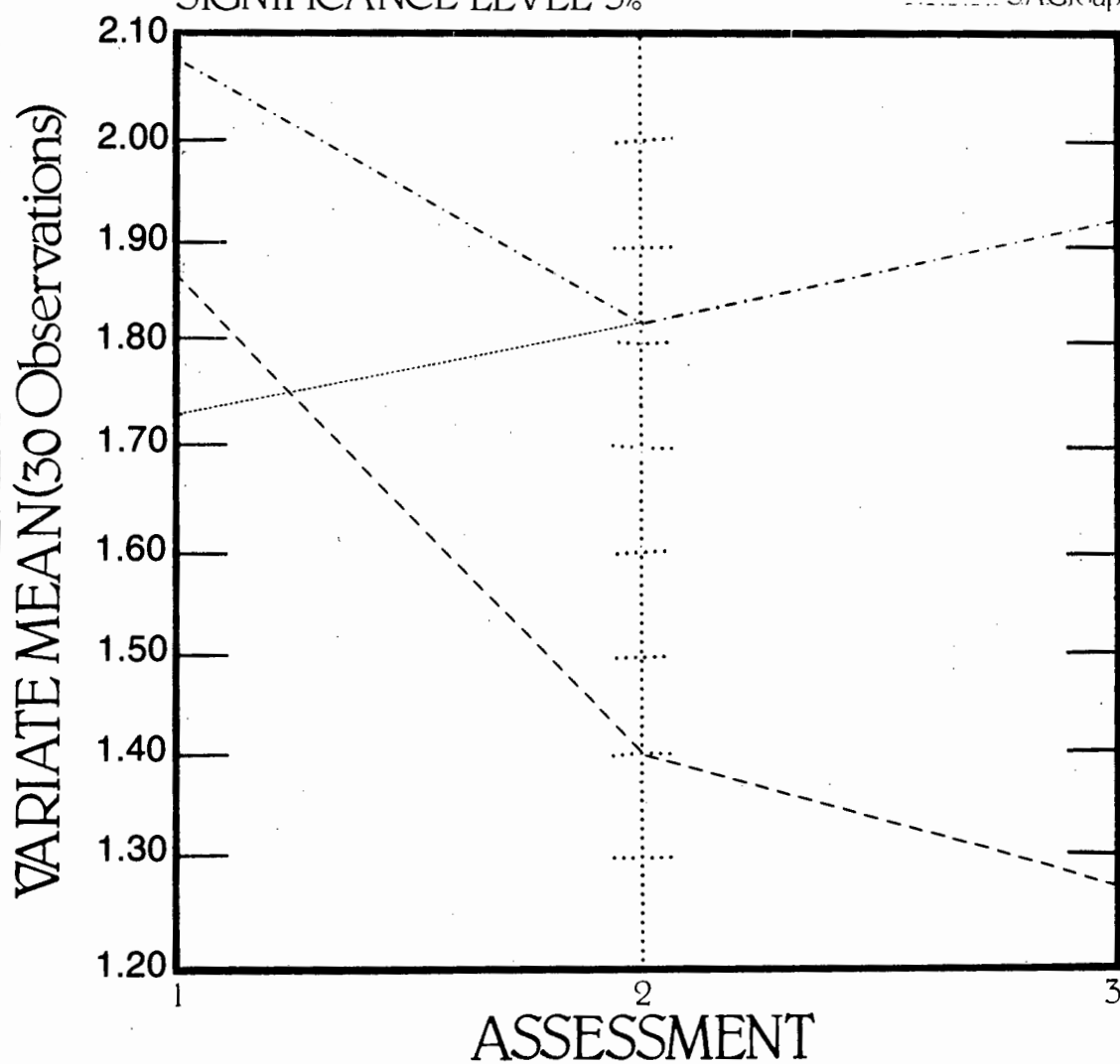


Fig.32 PLOT OF ASSESSMENT X TREATMENT

VARIATE-PPM7 S.E-.2315
SIGNIFICANCE LEVEL-1%

..... Control
----- C.I.Group
..... S.A.Group

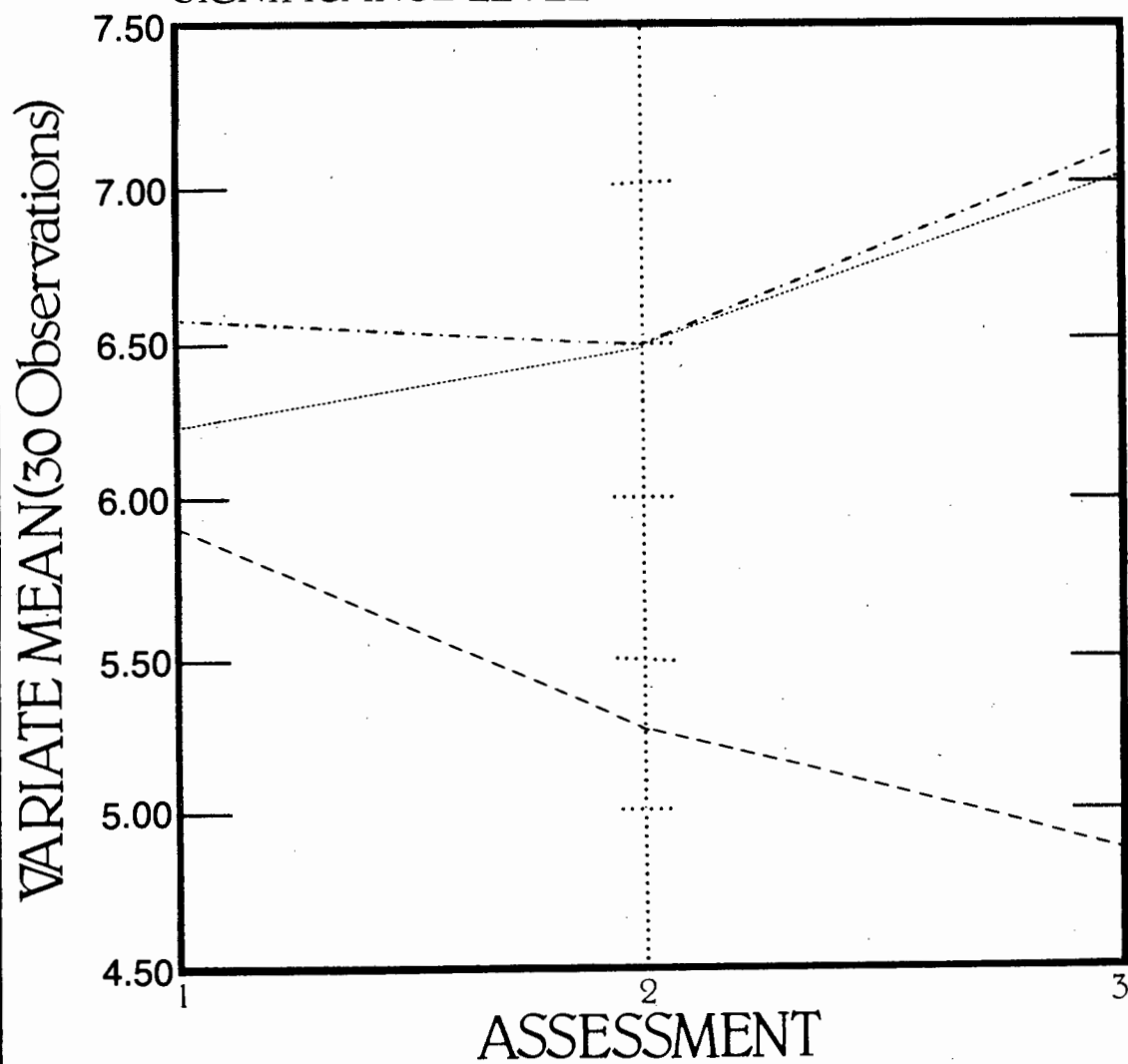


Fig33 PLOT OF ASSESSMENT X TREATMENT

VARIATE: PPM8 SE: .2757
SIGNIFICANCE LEVEL: 5%

..... Control
----- C.I.Group
----- S.A.Group

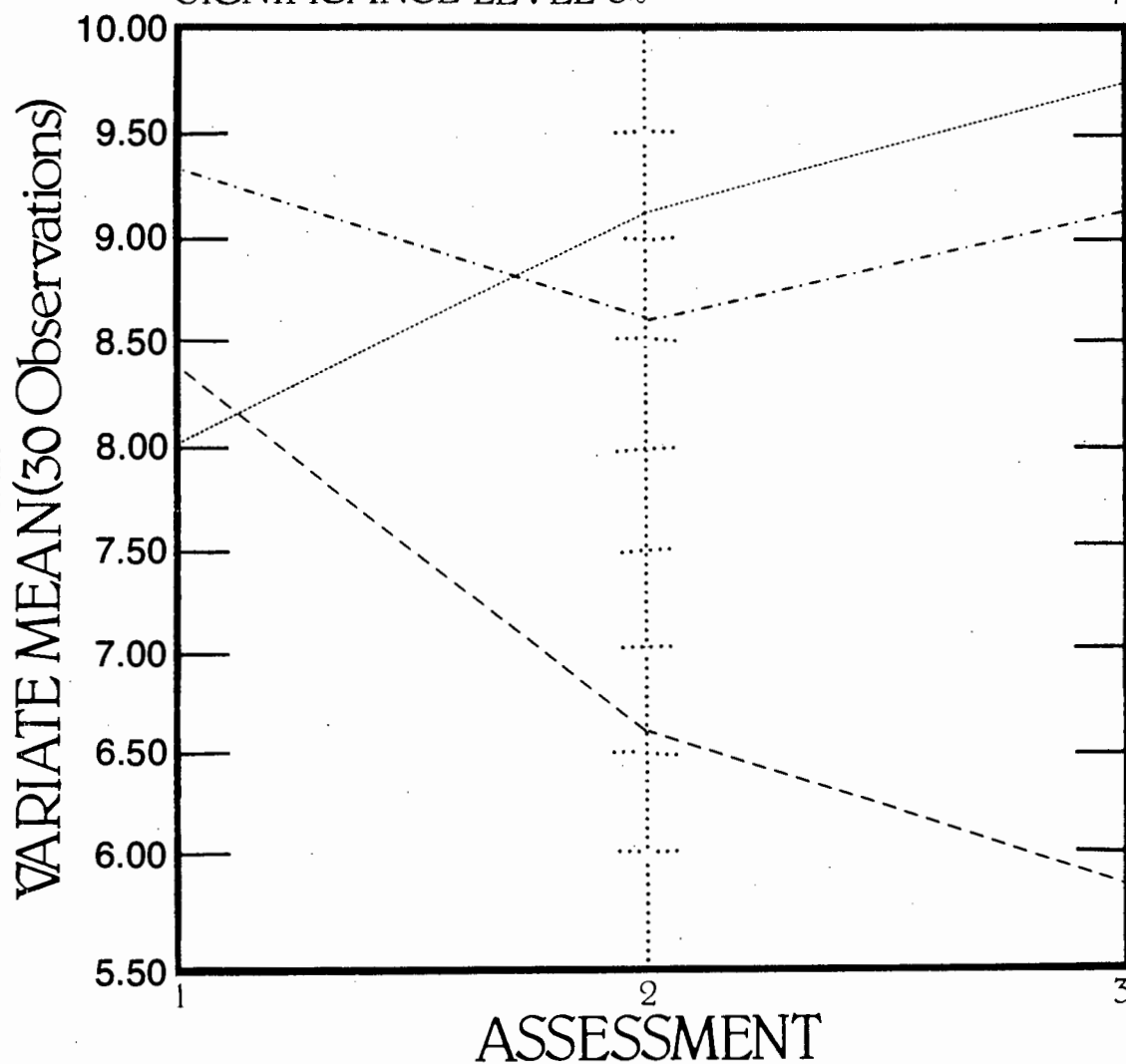


Fig.34 PLOT OF ASSESSMENT X TREATMENT

VARIATE:- SE-.1054
SIGNIFICANCE LEVEL-5%

..... Control
----- CI Group
..... SAGroup

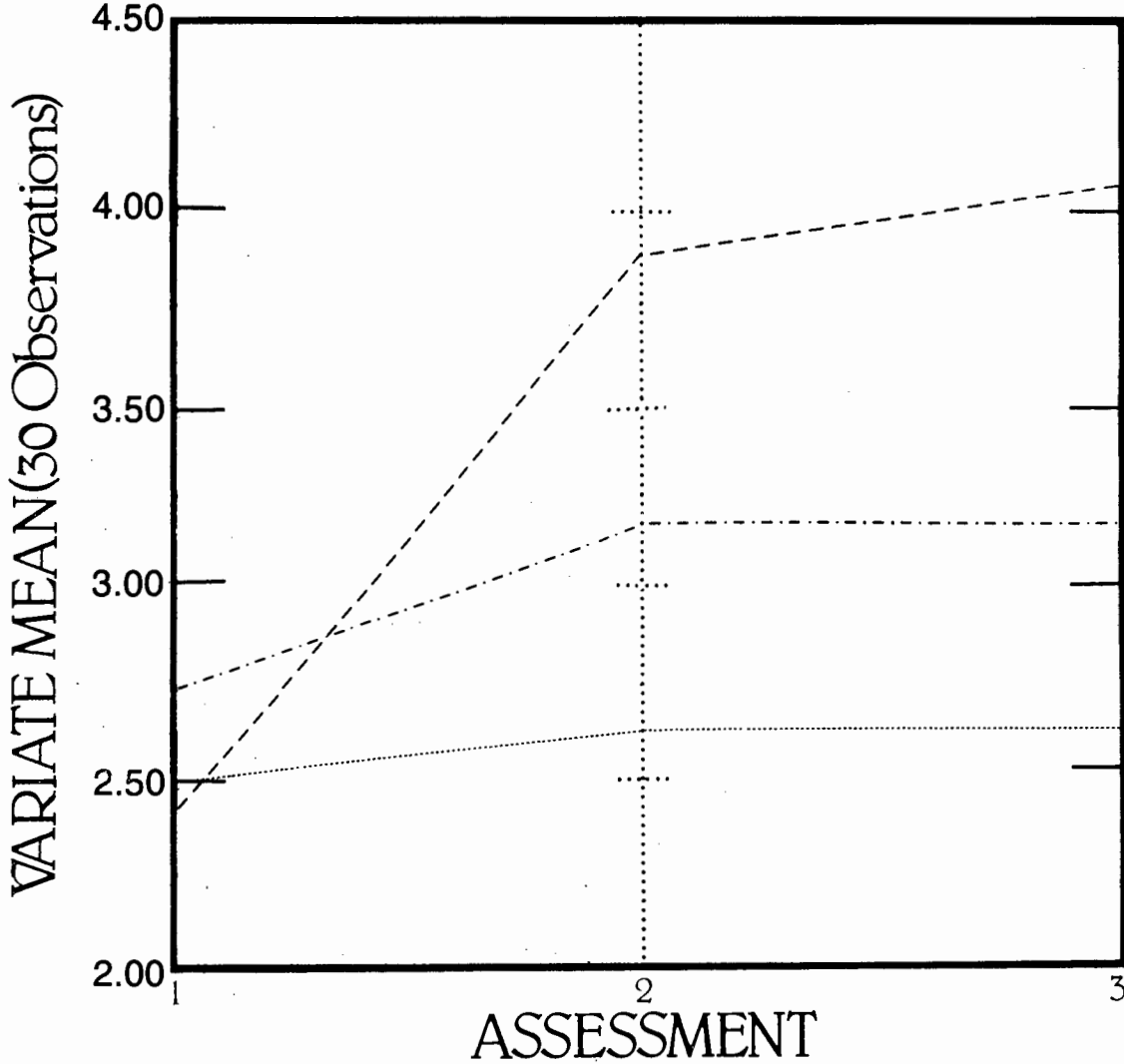


Fig.35 PLOT OF ASSESSMENT X TREATMENT

VARIATE-PTA2 SE-.1285

SIGNIFICANCE LEVEL-5%

..... Control
----- CIGroup
..... SAGroup

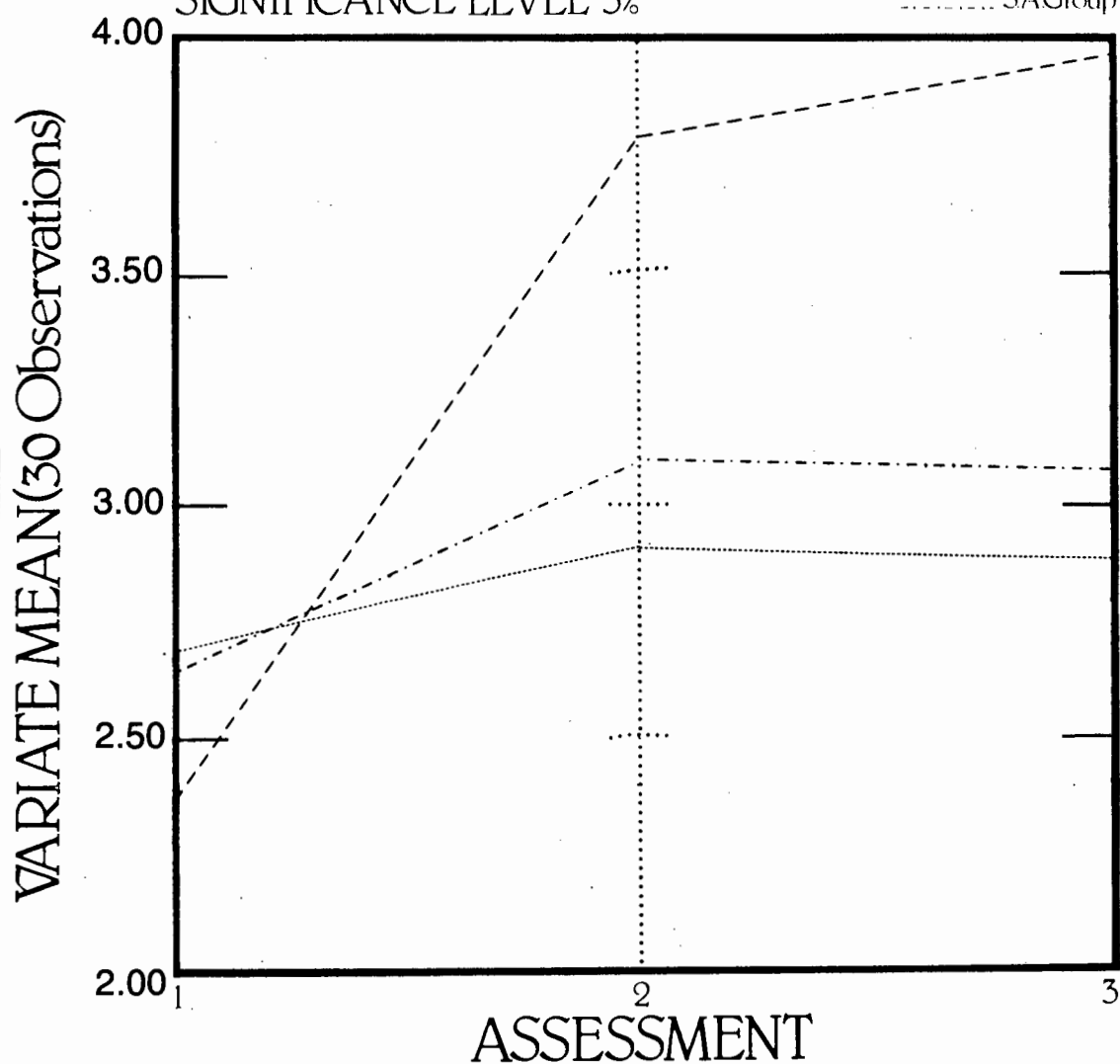
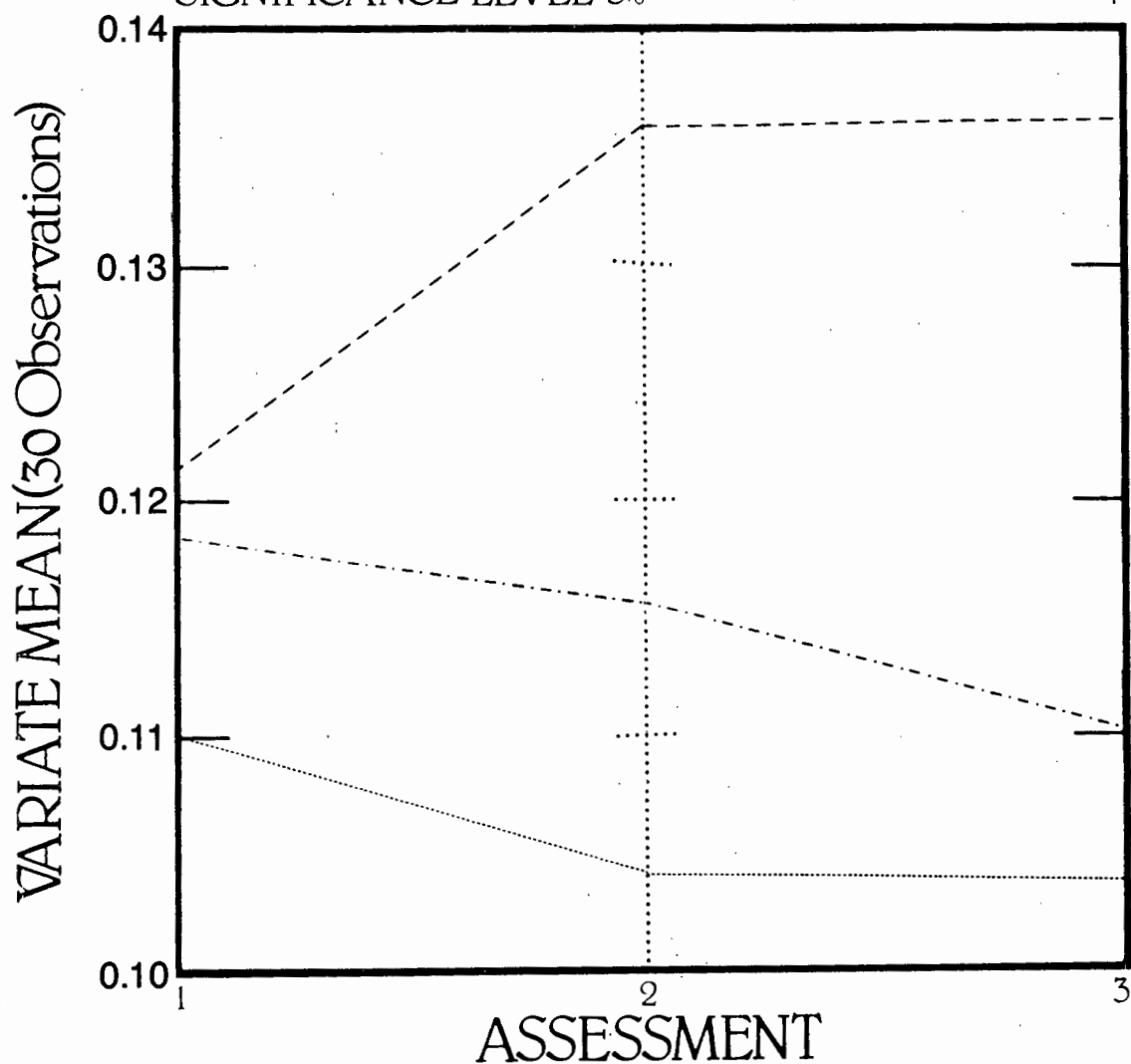


Fig36 PLOT OF ASSESSMENT X TREATMENT

VARIATE: PLO7 SE-.0027

SIGNIFICANCE LEVEL-5%

.....Control
-----CI Group
.....SAGroup



CHAPTER 8

‘Do not go gentle into that good night,
old age should burn and rave
at close of day.’

Dylan Thomas.

Discussion. General Discussion.

Before discussing the effects of the research study on the adjustment of White South African residents, fluent in the English language, to living in residential old age homes in the Greater Cape Town Area, we must ask ourselves the following question: Were the three groups approximately the same to start out with? (See Hypothesis 1).

Considering the social variates measured prior to commencement of treatment, it was found that there was no significant difference between the three treatment groups with respect to marital status, years widowhood, educational level, occupation and financial status. The null hypothesis is therefore accepted, without which one could not proceed with the rest of the research. In the case of the last three factors, this lack of significance is probably due to their high correlation with choice of home which was a factor in the experiment and is thus totally confounded with these effects.

Possible implications of these findings suggest that persons of a certain socio-economic class are only going to apply for admission to those homes which they can afford to get into in the first place. Admission policies of the homes in question are in part determined by one's financial status. The wealthier one is, the more likely one is to gain access to a so-called 'better home'. Because one is paying more, perhaps one can demand more attention than those people who are simply existing on the charity of others. It is therefore not unfair to presume that one's financial condition affects one's self-image and the status accorded to one by others. Furthermore, it limits the capacity of one to pursue leisure activities or to seek help when in trouble. Herbert (1969) in a study measuring institutional

adjustment of the geriatric population in homes for the aged in Texas, U.S.A. found a relationship to exist between social class and personal adjustment, and social class and social adjustment as well as social class and group participation.

In summary, it appears that there is a strong argument to suggest that the adjustment of aged persons to the institutional milieu is affected by their social class background. However, in this particular study, home was a factor which confounded the author from being able to determine the extent to which one's socio-economic status affected the final result. It must be borne in mind that the design of the study did not specifically attempt to answer this particular question.

Personality factors of aged newcomers to residential settings were questioned as a source of confounding in the experiment conducted. One's 'personality' can be described in terms of the consistencies and regularities which 'characterise' one's behaviour in a wide range of situations and over a reasonably long period of life. However, one's personality can also be described by any general fact that identifies one and distinguishes one from any other person. One's 'personality type' is defined by a fairly arbitrary characteristic or set of characteristics which one shares with others of the same class or type, the possession of which distinguishes one from those who do not have that characteristic or set of characteristics, e.g., 'extraverted', 'schizoid', 'authoritarian'.

The so called intrinsic and pathological effects of physical aging on personality are sometimes difficult to distinguish from those effects which may arise as a consequence of disuse of functions, e.g., poor memory, social isolation, e.g., 'autism' and institutionalization e.g. 'apathy'.

There appears to be no evidence that the normal processes of aging produce sudden or substantial changes in personality, i.e., in the individual's identity, traits, values and so on. There are, of course, many gradual and cumulative effects, e.g., changes in intelligence, shifts of interest, alterations in appearance and in physical health and mobility. Their relevance to personality study lies in the alterations they bring about in the relationships between the person and his environment. Changes in vision and physical stamina, for example, lead to changes in occupational activities and leisure pursuits; changes in material assets and social roles (associated with living arrangements and marital status) lead to changes in the activities of daily living and to the adoption of age-appropriate values and attitudes.

The term personality can be used to refer to those stable patterns of adjustment which make up the individual's long term strategic adaptations. Thus in a classical study by Reichard (1962), five fairly distinct strategies of adjustment were identified, making it possible to classify aged people according to their personality types as constructive, dependent, hostile, self-hating or defensive.

The term personality can also be used to refer to the person's basic psychophysiological dispositions, e.g., his outgoingness, aggressiveness, and quickness, which seem to direct and limit his behaviour, and to enable him, with experience, to acquire adaptive skills and routines.

Personal adjustment, in the sense of evolving an effective long-term adaptation to one's environment seems to demand at least three basic achievements : the resolution of conflicts (both within the person, and between him and his environment), the fulfilment of his potential and the elimination of inconsistencies and contradictions in his behaviour and experience. Personal adjustment in adult life sometimes calls for tactical adjustments to unforeseen circumstances,

i.e., adjustments which cannot be made by recourse to familiar and habitual reactions. The main point of a strategy of adjustment is to minimise unforeseen problems and to facilitate the achievement and maintenance of long term rewards by means of actions designed to prevent, to circumvent, or to cope with the various problems and obstacles that are expected to arise.

Among the more important sorts of tactical adjustment in adult life, are those associated with what have been called 'psychosocial transitions' (Neugarten, 1970; Parkes, 1971) e.g., bereavement, illness, retirement. One of the most striking features of adulthood and old age is the unpredictability of life events. Whereas the juvenile period is characterised by a relatively orderly and systematic programme of developmental stages, carefully nurtured in a regular sequence of domestic, educational, and social settings, the adult period is characterised by a relatively disorderly and unsystematic series of breakdowns which interact to produce diverse and cumulative impairments of functional capacity, often in the absence of remedial and supportive settings. Consider, for example, physical disability and isolation, depression and suicide.

An adult's environment is normally arranged in such a way as to minimise stresses and to avoid pushing the individual close to the limits of his functional capacity. However, other people form a major part of the individual's personal habitat so that, in later life particularly, there are unpredictable changes in his physical and psychological capacities brought about by disease and damage, and equally unpredictable changes in the physical and psychological capacities of other people upon whom his personal adjustment depends. Thus, the aging individual is

constantly having to readjust his changing capacities and inclinations to changes in his environment, especially his social environment. These readjustments are initially 'tactical adjustments', in the sense that the individual cannot put into operation an effective pre-arranged course of action (having had little or no experience of such problems); so he has to resort to short term measures which reflect his basic psychological resources, e.g., optimism, intelligence, confidence in people, and his weaknesses, e.g., dependency, jealousy, and casualness.

(Bromley, 1978, pp.33-34).

Following this rationale, one may argue that adjustment to an aged home is largely influenced by personality factors (character profile). The assumption is that those aged with pre-institutional traits that are congruent with the specific demands of the relocation environment will experience a minimum of distress due to relocation. Such congruent personality traits may facilitate adaptation because the impact of relocation is lessened when there is a relationship between traits and specific demands of the environment. An environment that rewards hostility, for example, may be a facilitating one for the hostile, and even paranoid person.

To establish whether such a relationship existed in the present study, the character profiles of the three groups were examined for statistical significant difference on the 16PF. Results suggested that the null hypothesis should be accepted (hypothesis 2). That is to say, there was no difference between the three groups.

Twelve of these variates were significantly different amongst the homes, namely :

Aloof (schizothymia) vs. Warm, Outgoing (Cyclothymia)

Emotional (General Instability) vs. Mature (Ego Strength).

Happy-go-lucky vs. Lively.

Trustful (Lack of Paranoid Tendency) vs. Suspecting (Paranoid Tendency)

Conventional (practical concernedness) vs. Eccentric (Bohemian Unconcern)

Confident (free from anxiety) vs. Insecure (Anxious Insecurity).

Conservative (Conservatism) vs. experimenting (Radicalism)

Dependent (Group Dependency) vs. Self-Sufficient (Self Sufficiency).

Uncontrolled (Poor self-sentiment) vs. Self Controlled (Somatic Anxiety).

Anxiety and Introversion (Two second-order factors)

This means that it was not possible to examine adjustment in the light of character variates independently of the choice of home. The implication of this finding once again suggests that the admission criteria of the various homes in question are likely to influence where the newcomer goes. Homes which cater for the socio-economically better-off individual are likely to require that the individual demonstrate the more positive personality profiles, whereas those homes which cater for the poorer type of resident do not expect much in terms of character profiles and, more often than not, these residents are expected to be more eccentric and less integrated. Thus to all intents and purposes we find that there is a link between social variates and homes and character profiles and homes.

The literature points out that social class not only affects where the patient or resident is admitted to, but also the kind of treatment they receive. Hollingshead and Redlich (1958) discovered that people who had more money tended to be diagnosed as having less serious difficulties. One might conclude from this study that the environments

of upper class patients and rich people make their psychological difficulties less serious than those of less affluent individuals. Or it has been suggested that, because they are similar in social class and appearance to the 'helpers' who treat them, rich people are less likely to be seen as seriously disturbed than people from the lower classes, whose different habits and manners might be interpreted as destructive by a helper who did not understand them.

This notion has created the idea that in the case of the educationally and financially better-off individual, there is a greater sense of personal security.

We do not expect older people from this background to demonstrate low productivity or little drive nor present with decreased emotional responsiveness. However, in the main, we do expect those older residents who have come from 'good backgrounds' to have more integrated personality profiles and so adjust more quickly to changed life circumstances. In fact, as Lowenthal and Chiriboga (1973) have demonstrated, many of the maladjustments that occur in old age arise as a consequence of relatively normal psychophysiological impairments and common sorts of environmental stress. Implicit in their research is the fact that one's personality profile is the intervening variable that determines the outcome of the precipitated conflict.

Unfortunately, the nature of the present research design does not allow the full benefit of this hypothesis to be explored more fully and therefore the inferences drawn remain merely tentative, until confirmatory evidence is produced. More research is therefore indicated in this area.

It must be remembered that the problem posed by this research is of a twofold nature : (a) which treatment alternative is likely to be more successful in minimising the adjustment reaction of aged

residents, and (b) Is the outcome of one's adjustment reaction likely to depend purely on the treatment alternative applied or do confounding variables such as personality profiles (character profiles), effects of the home, and socio-economic criteria affect the results.

It has been found that several factors are correlated with home and cannot be distinguished from that effect. However, these factors should not affect the results of the experiment since they were not regarded in the allocation of subjects to cells and so should be equally represented in each cell. That is to say, these variables are equally distributed between the three groups and the three groups are therefore comparable.

The broad objectives of the study were then to look at the effects of treatment on biological, sociological and psychological/psychiatric parameters at the various levels of assessment. The data was subjected to a multi-variate statistical analysis in order to ascertain which treatment alternative was likely to be most successful in minimising the adjustment reaction that aged folks experience upon being institutionalized in a residential setting.

With respect to biological variates, when we think about old age, we are virtually socialised into imagining a deteriorated, lethargic, bedridden person living out his last days in the sterile isolation of an aged home or other total care institution. The physical plight of many of the older persons living in caretaker institutions is often quite serious and one expects elderly residents to present with a great many physical symptoms. Self reports of dizziness, weakness of limbs, shortness of breath, pain, headaches, nausea and other general malaise, are extremely common. That is to say, a great proportion of the population who 'land up' in aged homes often present with multiple impairments, namely, sight, hearing,

ambulation, mentation and self-care ability. In many cases one finds that it is these very factors which have precipitated the admission to the home in the first place.

Do these variates change during a resident's first three months in an aged home? Are they influenced by the type of treatment employed? And if so, are biological changes linked to changes in one's psychological state? The last question opens up the issue of psychosomatic precepts. Psychosomatic medicine is a modern, if not entirely new, concept - a general approach to the science of healing which aims at stressing the significance of psychic factors in the formation of the diseases and, in particular, their importance in the structuring of therapy.

According to the neurophysiologists, all stress situations lead to an activation of the hypothalamus, which immediately sets protection and defence mechanisms in train along motor, visceral and neuro-hormonal pathways. At the same time signals are transmitted to the cerebral cortex so that the emotion is perceived and recognized. If the threat to the organism continues, the forces maintaining the internal equilibrium must remain active longer. This can lead to peripheral, functional or even organic disturbances in the systems affected. Modern anthropology and psychology, which look at man in terms of his social and interpersonal relationships, emphasise the conflicts arising out of these relationships and stress their importance as a factor in the causation of psychosomatic disorders. Thus, for example, retirement from an active, and highly satisfying occupation can lead to a sudden deterioration in a person's health. Coupled with this fact may be an associated drop in status as well as a depreciation of his capital investment. The crippling effect of all these stresses on mind and body leads not infrequently to psychosomatic symptoms being

presented. The symptoms are directed to mostly the organs of ingestion, digestion, and evacuation; that is, to the gastrointestinal tract and to the heart and circulatory system. This does not mean that the reproductive system and the muscles, bones and joints are excluded from attention. The over-concern that the patient pays to his symptoms is an expression of the desire to be taken care of. By his unconscious use of the resulting physical symptoms, the older person often attempts to regain the attention, affection and domination that he/she once held.

Looking at the results obtained from this study, we find that the first biological (null) hypothesis is accepted. That is to say, there is no significant difference between treatment groups with respect to any of the biological variates at any single level of assessment nor over all levels of assessment.

Furthermore, there is no significant difference between the control and the other two treatment groups nor between the two treatment groups - Crisis Intervention and Social Activity, with respect to any biological variate. With respect to biological variates, there is again no significant difference between assessments at any single level of treatment, or over all treatments. There is also no significant difference between Assessment 2 (at the end of treatment) and Assessments 1 and 3, nor is there any difference between Assessments 1 and 3.

It was also found that with respect to biological variates, there was no significant difference in the way values changed with assessment from one treatment to another, except in one case. The Lefevre Morbidity Pain Scale showed a significant difference at the 0.5% level for one particular comparison. The CI group showed a decrease in pain from Assessment 1 to 3, while the SA group increased. The control group decreased slightly although this comparison is not significant.

Let us try to understand the meaning of such a finding.

A common feature of old age which begins in the middle years is 'body monitoring' - the need to concern oneself with the care of one's body and its functions in a more concerted way than before. As an adjunct to this, pain is another frequent pre-occupation for the aged. The periodic aches and pains of rheumatism, the throbbing relentless pains of arthritis and the sharp distress of angina pectoris are all examples. Older people, aware of discomfort, are often unable to isolate its source. In a sense, one's reporting of the 'pain sensation' can have four purposes. Firstly, it may be the body's way of signalling and registering the beginnings of some life threatening illness; secondly, it may reflect the consequences of actual organic dysfunction; thirdly, it may be hypochondriacal, i.e., a means of drawing attention to oneself, a ticket to interaction with caretakers - doctors, nurses, etc., and, finally, it may be associated with depressive feelings. Luban Plozza and Poldiner (1974) suggest that the pain syndrome is one of the somatic symptoms of prolonged emotional strain. Unfortunately, the rather crude instrument of which the parameter is a part, does not allow us to ascertain which alternative is being expressed. As we have, however, noticed, this variate changes after crisis psychotherapy which may suggest, to all intents and purposes, that alternatives three and four are the more operative aspects in the continuum. That is to say, the abatement of pain may be associated with the fact that depressive symptomatology subsides in the group which is exposed to crisis intervention. Perhaps members within this group no longer feel the need to draw attention to themselves, having resolved their feelings about being institutionalized.

It must be stated that this interpretation is tenuous and may simply

reflect an artefact of the experimental design. As had been pointed out in the statistical analysis, the result obtained was achieved by one subject in the control group changing from a value of 3 to 2, one in the CI group changing from 3 to 1, and three in the SA group changing from 1 to 3, 3 to 2, and 0 to 1.

It was found that six of the biological variates were significantly different between different homes. These were namely :

1. pain
2. dyspnoea
3. stiffness/weakness
4. physical self-maintenance.
5. self-care dependency
6. physical infirmness (see Table 7.4.3).

This implies that the residents in the various homes differ with respect to characteristics such as morbidity, self-dependence and physical infirmness. In other words, admission criteria determine whether a person with a particular sort of physical profile will be admitted to the home in question or not. Some homes are geared to containing individuals whose physical functioning is markedly deteriorating, others are not.

In the final analysis, the author concedes that the biological variates measured at each assessment show too little variability between design cells to be of use in evaluating the different treatment methods. Perhaps the questionnaires being used to assess these changes are too crude. Simon, Lowenthal and Epstein (1970) have included four indicators of physical status; namely, number of hospitalizations preceeding admission, physical complaints, physical diagnoses and physical impairment.

More sophistication in data gathering techniques is therefore suggested if we are to maximise the chances of noting biological changes that occur within the first few months of the aged newcomer's life in a residential setting.

Using a dialectical framework which believes that there is a definite interaction between individual psychological development, physical status and the social conditions by which we live, one would expect that significant changes in one dimension produce concomitant changes in other areas. The findings of this research have yielded significant changes in both psychological and social variates in residents who have been treated with crisis therapy and one would have expected certain gains in their physical status which was not actually forthcoming. Likewise, one would expect depreciation in the control group's physical status. The fact that no supportive evidence of this nature was indicated does not point to a weakness in the theory but, more likely, to inadequate application of data gathering instruments to assess changes which may, in the final analysis, be difficult to record anyway. Possible further explorations of refined physical changes on EEG, ECG and blood pressure readings may be indicated to highlight this interactive effect.

We have previously intimated that the aging process poses many social problems and it is often perceived as a period of social withdrawal with concomitant deprivation. It is the stage of development when losses are most pronounced and these affect the social status of the person more seriously than do similar losses earlier in one's life. The commonly held beliefs regard the elderly to be isolated and rejected by their families. Adages such as "one mother can raise ten children but ten children cannot care for one old mother" are solemnly cited

as being typical of the attitudes expressed. The urban, industrialised society which, thus far, has placed little value on the virtues of old age, has been singled out as the annihilator of the extended family and its network of mutual assistance. The question must be raised as to whether research evidence supports this contention.

The emerging evidence is conflicting. Butler (1977) claims that despite the different patterns of family life in which extended kin live in separate households, strong, viable and supportive relationships are maintained. Aid to the elderly takes the form of economic help, living arrangements with families when this is imperative, and affection and companionship. When families do not offer help to their aged, a whole range of personal, social, and economic forces are usually at work, rather than a simple attitude of neglect.

Shanas (1968) suggests that many old people manage to maintain both their own homes and involvement with kin - a pattern aptly characterised as intimacy at a distance. In a study done by Shanas, 90% of respondents aged 65 and over reported having seen one of their children in the last month. This reflects the accessibility of kin, with three-quarters of older people having a child who lives less than thirty minutes away. She goes on to argue that the rejecting attitude of younger members of the family in their approach to their aged is a myth which has been perpetrated by two groups :

- (1) Professional workers in the field of aging who deal with a biased sample of those elderly who do not have normal support.

- (2) There are the childless old people who are likely to believe that the aged are neglected by their children. This group constitutes one fifth of all elderly people.

Peterson (1970) in reviewing all the evidence on contemporary

kin relationships, finds considerable support for the thesis that family relationships do not offer substantial intimacy or emotional support to aging persons. The elderly regard their contact with kin as being too infrequent to provide companionship. If money and services are provided it takes place with minimal affect and interaction.

Vickery (1978) suggests that there is concern in our society that a growing irresponsibility and lack of respect exists on the part of too many adult children for their aging parents. Emotional closeness between parents and children is not something that we take for granted. How close this relationship is in old age is determined by the quality of relationship during earlier life periods ...

A grown child may love his parents but still harbour resentment and hostility from childhood injustices, real or imagined. If there were open conflicts and misunderstandings then, the hurts will still be deeply felt by both parents and children.

Parents may both love and resent adult children - resent because they no longer control their children, and because their roles are now in fact reversed. Adult children too often try to take over and make decisions for their parents. They mean well but often manage too much! (p.63)

In the case of illness or other crises, aged parents depend more on their children and their needs place a greater demand on their childrens' financial and emotional resources which often induces emotional disturbances in the adult children. Sainsbury (1960) found that at the time when patients aged 65 and over, first came to a psychiatrist for help, over three quarters of their family were suffering from symptoms of emotional disturbance such as insomnia, headaches, irritability and depression. Social and leisure activities were restricted

in half of the families, and the physical health of the closest relative was affected in the third. In some cases, the domestic routine of the home, housework, shopping etc. was upset.

The inability of the family to care for their aged relative(s) is one of the foremost reasons for admission to an aged home (Townsend, 1962). When numerous difficulties are created by 'three generations living', Grollman and Grollman (1978) claim the common attitude expressed is :

"If my parents stay in my house for one more day,

I think I'll have a nervous breakdown

But they can't manage alone

Is an aged home the only solution?" (p.106)

"Oh my God, how can I do this to them?"

From the above, we clearly see that the ambivalence in family members is marked, both because of the negative reputation of institutional care and because of their own feelings of failing or abandoning the aged person. Some experience a sense of relief, about which they later feel guilty. Families who care often experience a grief reaction on admission as though the person had already died. This "death" may be more traumatic than the actual death of the older person later on. In some cases, family members may actually stop visiting the person because of an inability to tolerate their own guilt, grief and ambivalence. It is therefore clear that the decision to institutionalize a loved one is among the most difficult anyone is ever required to make. Aged folk regard the home as the last stop, a kind of purgatory, halfway between society and the cemetery. No doubt, the decision to place aged folk into a new environment evokes

marked feelings of anger, hostility and rejection in them ...

You are blamed for

the irreversible deterioration of their bodies

their inability to take care of themselves

Your seeming unwillingness to care for their needs

(ibid, p.116).

In summary we see that institutionalization has a marked effect on both the newcomer as well as his/her family and we are therefore particularly interested to note whether psychotherapy can alleviate some of this animosity. If this is the case, one may then hypothesise that there is less likely to be a disturbance of continued relating during the resident's stay in a new environment. In other words, if the therapist can contain some of the anger which is directed toward the family and allow the newcomer the opportunity of expressing and working through the hostility experienced, he/she is less likely to continue making close relatives feel guilty, which in turn allows them to adopt customary supportive roles.

Towsend (1962) highlights the lack of community involvement with its accompanying loneliness as being important factors which precipitate admission to an aged home. The situation is likely to worsen once admission has taken place. Relocating can be destructive to the resident's ability to function in the new environment in that it often involves separation from friends, possessions, home and familiar surroundings. A new resident is faced with a loss of continuity with his/her former life patterns. Excluded in part from the community, economically dependent, and no longer productive, he/she is confronted with being transformed into a societal reject, New residents have to

unlearn much of their former life style so that they can tolerate congregate living and cope with a loss of privacy and individuality. Life in a home often actually means becoming disengaged, emotionally flat, without motivation and mentally withdrawn. One of the questions that the present research raises is whether community re-engagement can at all be facilitated by psychotherapy, once admission to the home has taken place.

Results indicate that there is no significant difference between the three treatment groups with respect to significant caring, family involvement, and community involvement at one single level of assessment or over all assessments. That is to say the null hypothesis is accepted.

Furthermore, it was found that there is no significant difference in any of these variates between the control group and the treatment groups together. However, the community involvement variate SCOI shows a difference, significant at the 5% level between the CI group and the SA group. The CI group is the most extreme of the three groups (Table 7.4.4).

Considering the assessment means for each treatment group separately we find that community involvement (SCOI) shows significant differences at the 0.5% level in the control group and CI groups. The means for each group are plotted in the graphic interpretation of results (graph 4) and it can be seen that the control group decreases with respect to this variate while the CI group increases over assessment. That is to say, it appears that the control group deteriorate and become more isolated, withdrawn, and apathetic. They are unable to engage in social contact and hence make little use of social or community services. Alternatively, these aged residents who have been exposed to a crisis intervention program, become more socially integrated over

the first three-month period in a residential setting. These people are able to avail themselves of social services and therefore maintain links to mainstream community life.

It is interesting to note that the significant caring variate (SSAC) differs significantly at the 5% level between assessments in the CI group. The mean changes from 4,90 at Assessment 1 to 5,20 at Assessment 3. That is to say, the attitude of the significant person to his aged relative changes from being less supportive to being more supportive. After therapy had taken place, the interaction between these two people changed to one of more respect, care, and concern. The previous responsible caretaker seemed able to get closer to his/her aged relative. In attempting to understand this shift in attitude, the present author would like to offer the following interpretation. One of the specific goals in the therapeutic situation was to encourage the expression of relevant affects. Feelings of anger and rejection at having been abandoned by the closest blood relative were close to awareness in the aged person's experience. The worker picked up on these cues and was able to take the projections of hostility and deal with them therapeutically, thereby allowing the opportunity of a continued relationship to operate in two persons who were previously locked in a conflict-ridden situation. In other words, perhaps the movement in a positive direction occurred because of the resident's ability to dispense with feelings of hostility and rejection post-therapeutically.

All three variates show a significant interaction between treatment and assessment (SSCA + SFAI at 5% and SCOI at 0.5%). See graphical interpretation of results (Nos. 2-4). The nature of the interaction is clarified by considering the special comparisons in all three variates: the comparison (between Assessments 1 and 3) x (between treatments) is significant. This means that the difference in trend from

Assessment 1 to 3 was not the same in the CI group as the SA group.

To summarize the findings as regards social variates, it appears that exposure to crisis intervention has enhanced the resident's ability to relate to their families. Amongst this group, links to the outside world have remained intact and in most cases they have been strengthened. The control group appeared to deteriorate whereas little or no change was evident in the social attachment and activity group. Social adjustment is therefore enhanced in a treatment group that has specific goals to remotivate, resocialize and explicitly diminish the potent effects of institutionalization. Viewing institutions in terms of barriers created to social interchange with the outside world, Goffman suggests that the more total the institution, the greater the depersonalizing effect. Therefore it seems important to provide aged residents with the techniques to break down the barriers, not only with regard to the external world, but in the internal system of the institution. For the newcomer entering the institution, the issue is to reduce the chasm between the old and familiar and the new and the strange. In the past, ad hoc, theoretical resocialization programs have been instituted with varied success; however, few studies have provided residents with a conceptual framework with which to view their plight. The seemingly appropriate direction given to the aged resident by the worker has definitely enhanced social adjustment.

Examining the psychological variates, we find more consistent changes in these parameters when comparing them to both biological and social variates. Results have indicated that there were statistically significant psychological changes between the three groups at each level of assessment. Bearing this in mind, it was important to discern whether there was any significant psychological changes between the

control group and the two treatment groups at each level of assessment, which there was. Looking at the two treatment groups to see which has contributed to the majority of changes, we find that the crisis intervention group has made major changes with respect to psychological variates at each level of assessment (see Figure 1).

The above result reflects the conglomeration of all psychological parameters. In the following section however, we shall look at individual variates and examine how they change for aged newcomers within their first three months of residency.

Looking at the result obtained from the Becks Depression Inventory which is a psychometric measure of both the biological concomitants as well as the cognitive features of depressive symptomatology, the following trends were obtained (figure 5). There is a significant difference between the Crisis Intervention group and the other two groups at each level of assessment with respect to this measure. At admission to the various aged homes, all three groups appeared to start out with similar scores of depression. That is to say, they all had similar feelings of worthlessness, were without significant goals in life, and without a meaningful program for the future; furthermore, they demonstrated a lack of optimism and hope and were frequently pre-occupied with their health. Behaviourally, these individuals showed similar features of psychomotor retardation in speech, gait and thinking; lack of appetite and weight gain, fatigue, feelings of exhaustion, etc., etc. The exact etiology of these symptoms is unclear, but the following aspects combine in various forms to produce the above mentioned picture :

- (a) deterioration in physical health
- (b) loss of social status and prestige.
- (c) loss of significant caring and supportive relationships.

- (d) loss of independence.
- (e) isolation and removal from mainstream community life
- (f) fear of dying in an aged home, emotionally uncared for.

Following the specification of the design, two forms of intervention were applied to two groups immediately after the pretest had been completed and this was then compared to a group who had received no treatment during the same time period. Scores after the post-test revealed the following result. The Crisis Intervention group had dropped in their level of depression, as had the social attachment and activity group, but not to the same degree. Scores in the control were seen to have increased, which implied that members within this group had become more depressed.

At Assessment 3 (the follow-up), scores in the CI group continued to drop whereas the SA group scores increased and approximated the direction of the control. The control group scores had risen continuously over the initial three month period which suggests that aged persons who are not exposed to some form of intervention are likely to deteriorate markedly with respect to depression.

By a process of deduction, it therefore appears that exposure to a Crisis Intervention program in the first five week period post admission has arrested the negative and pessimistic feelings associated with being institutionalized and has enhanced the resident's ability to see the environment in a more favourable light. This is borne out by the fact that immediate gains which have been acquired through intervention seem to have been internalized and carried forward allowing the person to continue making good progress (see Assessment 3).

What is it about Crisis Intervention per se that enhances the therapist's ability to make such a dramatic breakthrough with regard to

the variate of depression in a group of old persons having been placed in what appears to be their last home? Possibly the depression associated with placement into an aged home relates to the loss of self-esteem which in turn results from the aged individual's inability to supply his needs or drives (loss of narcissistic supplies) or to defend himself against the threats to his security. Therapeutically it becomes important for the resident to feel able to express the many negative feelings associated with institutionalization. The Crisis Intervenor encourages the feelings of rage, anger, fear, grief and anxiety to be expressed, and by not responding antagonistically to them, newcomers learn that affective expression does not damage its recipients. Any issues troubling the newcomer can therefore be dealt with safely, giving the resident a feeling of being contained. Moving away from a position of simple catharsis, the therapist then encourages reflection on events that led to the decision to apply for residency in the first place with the aim being to provide the newcomer with an intellectual understanding of the crisis situation. Previous coping mechanisms are scrutinized and the less functional ones are actively discouraged. Ultimately, the resident is made aware of the situation that he/she faces with respect to future existence in a residential setting. That is to say, the newcomer is encouraged to take control and responsibility for his/her actions in the new environment. This has a definite paradoxical intention since many institutional systems are all too often insensitive of their inhabitants' need for control.

Let us try to understand why the control group do so badly with respect to depression. Undoubtedly, they view the situation more pessimistically, are less motivated to continue living and generally feel helpless about their life situation. Perhaps by regarding depression

as a function of helplessness it makes the issue a little clearer.

Reflecting on the etiology of depression, Bibring (1953) commented ...

What has been described as the basic mechanism of depression, the ego's shocking awareness of its helplessness in regard to its aspirations, is assumed to represent the core of normal, neurotic and psychotic depression.

F.T. Melges and J. Bowlby (1969) see the cause of depression in the following light ...

Our thesis is that while a depressed patient's goals remain relatively unchanged, his estimates of the likelihood of achieving them and his confidence in the efficacy of his own skilled actions are both diminished ... the depressed person believes that his plans of action are no longer effective in reaching his continued and long-range goals From this state of mind is derived, we believe, much depressive symptomatology including indecisiveness, inability to act, making increased demands on others and feelings of worthlessness and guilt about not discharging duties (p.691).

What causes a situation of helplessness to prevail in the aged home? Bennett (1963) has been able to shed some light on the issue by looking at some of the resident norms ...

- (1) a resident should neither criticize nor complain about issues with respect to the home.
- (2) Not only should he not criticize the home, he should praise it and come to accept it as his home.
- (3) Arguments should not occur with other residents and, in a sense intimate contact should be avoided.

Goffman (1961) suggests that withdrawal is forced upon newcomers by a system which continuously emphasises ritualisation and standardization, rigidity and inflexibility as well as role deprivation. Residents often feel anxious, vulnerable and afraid of the staff and the most common defense is to become depersonalized denying one's recognition of individuality or wholeness. To all intents and purposes one is forced into a helpless position, where there can be little or no expression of feeling without risk of social sanctioning.

Seligman (1975) has demonstrated the relationship between helplessness and depression. He is a learning theorist who sees depression as a result of a loss of reinforcers. The model he advocates suggests that the cause of depression is the belief that one's action is futile. An initial attempt to hide from the world becomes habitual and is made more rigid by the overprotection of those in responsible, controlling positions. The above formulation so aptly characterises the situation that an aged newcomer faces upon admission to a residential setting.

In view of the findings obtained, the author would like to offer the following interpretation. Old age has been described as a "season of loss", and depressive reactions are responses to losses. The theme of loss is cited by a number of authors (Pfeiffer and Busse, 1973; Shock, 1962; Kreps, 1969) to include inevitable declines in a physical vigour, mental agility, income, loss of loved one, and finally, one's own impending demise. The ubiquitous nature of loss in this time of life may be a factor to explain the high frequency of depression.

Depression with its biological concomitants may in turn be a precipitant for admission to aged homes in residents who do not have the familial, communal, or social support to sustain themselves. That is to say, its social implications and ramifications often force caretakers

of the aged person to consider institutionalization as the only possible alternative. Depressed persons are often exceptionally demanding and their accompanying dependency in most instances evokes hostility in those people around them. Unless the implied demands for nurturance and emotional support are perceived, these become even stronger and more irrational. The resultant anger is projected onto the caretaker who is not able to contain it and in turn reacts angrily withdrawing support. To all intents and purposes, an environment exists in which there is no containment for the aged relative on the one hand, whereas for the relative in question, the intrusion of having to care proves to be unbearable. Admission to a residential setting seems the only way out of this bind. The aged person feels rejected and sees the entrance to a home as a further obstacle to having his/her needs met. A period of quite severe disorganization ensues wherein customary methods or problem solving are no longer functional.

Unfortunately, in most instances, the institutional climate cannot contain the emotional crisis experienced by the new resident and he/she is forced to with-hold any negative emotional self-expression which ultimately induces a helpless position. Taking Seligman's (1975) model of depression into account, it is not surprising to find that behavioural responses are no longer made. However, the new resident has an enormous amount of hostility and we have to ask ourselves the question, what does he/she do with it.

Freud's (1917) paper on Mourning and Melancholia gives us the answer. Here he outlines some distinctions between grief and melancholia. Melancholia is concerned with unconscious loss or a loss of self-esteem :

grief involves the loss of an external object. Melancholic depression includes such affective states as being hurt, neglected, rejected or disappointed, and extends beyond a simple grief reaction at the loss of a libidinal object by leading to intense ambivalence.

Dynamic theorists assume that internalized hostility plays an important role in the development of depression. In the absence of a love object, or in the presence of intense ambivalence toward the object, aggression and hostility are redirected inwards by an individual. This results in feelings of guilt, self-hate, suicidal wishes, and an outward manifestation of passivity.

Returning to the aged newcomer, the author would like to postulate that what was once a possible precipitatory cause for admission to an aged institution later becomes a serious effect associated with residential living. It appears, therefore, that there might be a change in the endo-reactive continuum of depression so that in the absence of treatment, residents newly admitted to an aged home face stronger chances of becoming endogenously depressed. Following this rationale, the control group in this study are therefore at greater risk of affective disturbance.

The results which have just been discussed with respect to the variate of depression were obtained from the Becks Depression Inventory. This is both a reliable and valid psychometric measure. It is pleasing to note that these trends have been validated by the depression scale on the Brief Psychiatric Scale (see figure 12). Guilt, another symptom of depression, measured on the B.P.R.S. (see figure 10) approximated the same direction of the previous two results.

Examining the concept of affective responsiveness in terms of affect range and willingness to introspect we find the following results.

With respect to the variate of affect range (figure 34) a significant difference between the CI group and the other two groups at each level of assessment is found. Those residents who are exposed to crisis therapy are more in touch with a wider range of affects when comparing them to members of the other two groups. This is because the therapist actively encouraged the expression of feeling be it hostility, unhappiness, dislike, joy, interest, etc.

With respect to the variate of willingness to introspect, let us first consider its theoretical implications. Self disclosure, or the verbal communication of personal information about oneself and one's experiences, has been the subject of a considerable body of research.

The initial stimulus to the investigation of the concept was provided by Jourard (1964). His early work consisted of discussing the parameters for psychological adjustment. It was his contention that healthy personality functioning necessitated self-knowledge and an adequate "real self being". From research into the process of the presentation of such a "real self" to others, Jourard concluded that self-knowledge was paralleled by the willingness of an individual to communicate personal information to significant others in his life. He notes that ...

Full disclosure of the self to at least one other significant human being appears to be one means by which a person discovers not only the breadth and depth of his needs and feelings, but also the nature of his own self-affirmed values Jourard, 1968, p.427).

Conversely, it is held that :

... neurosis is related to the inability to know one's "real self" and to make it known to others Jourard, 1971, p.92).

On this basis it would seem likely, therefore, that measures of self disclosure would be positively related to indicants of adjustment and negatively related to measures of maladjustment and psychopathology. It could thus be expected that depression would covary with self-disclosure, with lesser self-disclosure associated with greater depression.

Taylor and Oberlander (1969) commented that, in comparison of reported low and high self-disclosers, low self-disclosers were significantly less able to discern and respond to interpersonal stimuli, such as incomplete faces, in a tachistoscopic presentation. While the authors suggest that these differences are a consequence of greater sensitivity to interpersonal cues on the part of high disclosers, these findings are also consistent with those of Cohen, Baker, Cohen, (1954) Fromm-Reichmann and Weigart (1954) and Ekman and Friesen (1974) in research on depression.

Examining our findings (see figure 35) the crisis intervention group demonstrate significantly more willingness to introspect at each level of assessment than the other two groups. The SA group show an increased desire to engage in self-disclosure after the cessation of treatment but made no further improvements at the follow-up assessment. The control group make little or no change at each level of assessment with respect to this variate.

Perhaps the crisis intervention group's high score can be seen to represent an indication of healthy adjustment whereas the control group's inability to make headway suggests the evidence of psychopathology. It will be remembered that this group show greater scores of depression which leads the author to hypothesize that depressed residents are likely to emit less self-disclosing behaviours than non-depressed persons. This finding is consistent with those of Hinchcliffe, Lancashire and Roberts

(1971), Shafter and Lewinsohn (1971) and Libet and Lewinsohn (1973) in investigations contrasting the verbal performance of depressed persons with control subjects.

Anxiety plays a central role in most theoretical systems in psychiatry. It is generally viewed as the result of intrapersonal conflict, or interpersonal conflict, or both, or as the result of threatening external circumstances. Anxiety is a complicated psychophysiological response. It may be defined as a subjectively experienced state of dread anticipation in which the object of one's dread is only vaguely defined. The term anxiety also includes the bodily manifestation of this uneasy mental state : muscular tenseness, restlessness, rapid heart rate, excessive sweating - all signs of preparedness for fight or flight.

Anxiety is a common symptom in old age. It may be present intermittently in response to a specific stress situation; it may be present chronically in some people; or it may be a concomitant of other psychiatric disorders. Neurotic disorder in old age, whether it arises de novo or whether it be an exacerbation of a longstanding condition, has always to be seen as a combination of personal predisposition, life experience and the stresses met in later life. Those elderly persons who have weathered the stresses of earlier life successfully may yet succumb to what in some cases, must seem an overwhelming collection of losses. The loss of social status, economic security, close ties of blood and friendship, physical health and bodily integrity.

Anxiety about ending up in a long term care institution is a common worry for older people. Twente (1970) argues that of all the moves to other housing the most dreaded is that of removal to an institution. Shanas (1962) suggests "almost all older people view the move to a home

for the aged or to a nursing home with fear and hostility

All old people without exception believe that the move to an institution is the prelude to death" (p.102). "An elderly woman recently came to our attention because she kept an arsenal of guns at home to use on herself or others if someone came to take her to a nursing home" (Butler and Lewis, 1977, p.236). These fears are realistic since entering a residential setting is definitely a time of major stress for the newcomer. Fear sometimes to the point of panic, perplexity, emotional lability, tearfulness, and feelings of helplessness dominate the psychological symptomatology.

One of the issues that this research attempts to explore is whether these symptoms abate after entrance to an aged residential setting. Do aged persons, without any form of active intervention have the resilience and determination to make a satisfactory adjustment? Does moving to a new environment improve their morale?

Considering the anxiety variate on the BPRS, (a measure of worry, fear and overconcern based solely on the basis of the verbal report of the resident's own subjective experiences) we find the following results (see Figure 9). There is a significant difference between the crisis intervention group and the other two groups at each level of assessment with respect to this measure. At admission to the various aged homes, all three groups appeared to start out with similar scores of anxiety.

However, after the cessation of treatment the CI and SA groups appear to be less concerned about their future whereas little or no change is reported by members of the control. It is during the next period, a gap of 6 weeks, that interesting changes occur. The CI group continue to make significant improvements as evidenced by their drop

in scores. On the other hand, the control group appear to become more anxious whereas the anxiety within the SA group increases slightly but is still below the original admission score.

With respect to the physical and motor manifestations of tension, 'nervousness' and heightened activation level - namely the psycho-physiological variate of anxiety on the BPRS - we find similar results (see figure 11).

When analysing the variate of excitement, we find significant differences between the CI group and the other two groups at each level of assessment. That is to say, the crisis intervention group have appeared to become less agitated during their three month stay in a residential setting whereas the control group have become significantly more reactive and display a heightened emotional tone. The SA group have not changed with respect to this parameter (see figure 19).

Considering the parameter of somatic concern, a measure of hypochondriasis (on the BPRS), we find yet again that there is a significant difference between the crisis intervention group and the other two groups at each level of assessment. The control group appear to demonstrate more over concern with present bodily health during their first three months of residency, i.e., the change from Assessments (1-3) is substantial (see Figure 8). The syndrome of hypochondriasis can best be understood as a psychiatric maladaptation determined by the patient's unwillingness or inability to acknowledge psychological distress. Being physically ill is a highly acceptable excuse for non-performance in our society. Non-performance as a result of emotional difficulties is far less acceptable or not acceptable at all by some individuals. It is fair to say that society regards the person who becomes emotionally ill with much greater ambivalence. While gross psychosis may be acceptable as an excuse for non-performance, more minor,

so-called neurotic complaints are often seen by the society and by many patients themselves as an unacceptable admission of personal failure. Escape from personal failure into the sick role is available at all ages but seems to be particularly frequently used by the elderly.

The hypochondrical patient has made an unconscious choice to present himself as physically ill. Three psychological mechanisms play a major role in the dynamics of hypochondriasis :

- (1) a withdrawal of psychic interest from other persons or objects and centring of this interest on oneself, one's own body and its functioning.
- (2) a shift of anxiety from a specific psychic area to a less threatening concern with bodily disease, and
- (3) the use of physical symptoms as a means of self-punishment and atonement for unacceptable hostile or vengeful feelings toward those close to the person.

To minimise the effects of hypochondriasis, it would appear that members within the control require psychotherapy to adopt a less poor idea of themselves and to gain support in reviewing their lives and sharing with the therapist a more optimistic, kindly and positive view of their achievements and abilities. The CI group seem to be less troubled by this malaise since there is no need to somatize their emotional problems having had the opportunity to work through them. At the follow-up assessment, on the other hand, the SA group appear to be moving in the direction of the control since more hypochondriacal behaviour is evidenced by members within this group.

From the collection of all symptoms pertaining to anxiety discussed so far, do we conclude that members of the control group show more features of psychoneuroses? Do we in fact define these symptoms as being characteristic of a typical neurotic condition or do they

pertain to the effects of a severe adjustment reaction? Alternatively, do they reflect features of what Barton has called the institutional neurosis? On the basis of evidence acquired, the author believes that it is impossible to make a definite statement but rather he chooses to adopt an interactive position whereby aspects of all three diagnostic options are seen to produce the clinical picture that we have been presented with. Despite the lack of diagnostic clarity, crisis psychotherapy has aided the individual in coping with stresses and anxiety associated with becoming a resident in an institutional setting.

Following depressive reactions, paranoid reactions are probably the most common psychiatric disturbance in old age. Paranoid patients are suspicious of persons and events around them and they often construct faulty, that is, unrealistic explanations of events which happen to them. Do people who have been placed in an aged home in the absence of treatment become suspicious?

From the results of this study, it would appear that the answer is yes (see figure 14). The control group became more suspicious at each subsequent level of assessment, whereas in the CI group, the direct opposite prevailed. While intervention is applied, the SA group make improvements with regard to the parameter of suspiciousness. However, the effects of treatment are not long lasting since members in this group do not seem able to withstand the pressures from the environment as at the end of the third month of residency, there is a strong resurgence of suspicious behaviour. Scores on the BPRS and corresponding PAMIE variate (figure 30) yield similar results.

Factors commonly found in the life situations of the aging that may contribute to the development of paranoid thinking include social isolation, insecurity and sensory losses. However, the onset of

symptoms may also follow acute stress such as the effects of institutionalization. In some instances it simply represents an intensification of a life-long pattern of hostility or suspiciousness (Post, 1965).

A certain amount of suspiciousness may actually be adaptive in the face of a treacherous environment. There is no doubt that the aged encounter more hostility and fewer opportunities in their institutional environment than do elderly people living in the community. Paranoid behaviour, like hypochondriasis, can provide an excuse for failure. The person can say that the fault lies not with himself but with "them". They are trying to harm him, are taking away his powers, and are trying to make him look ridiculous. Frequent as paranoid symptoms are in old age, it should be made clear that they do not have the ominous significance that such ideas have in younger persons.

It is thought that paranoid ideas give rise to hostility and unco-operativeness. If this is true in the absence of intervention, one would expect to find an increased score on measures of these variates. Confirmatory evidence was gleaned from the control since members of this group present with increasing scores of hostility and uncooperativeness at post-test and follow-up assessments. The CI group, on the other hand, made positive changes with respect to the parameters under investigation (see figures 13 and 14).

The discussion thus far has indicated that there are definite affective changes which take place during the resident's first three months of admission. Do our findings simply reflect the trauma initiated by permanent institutionalization? Are they simply part of what psychiatry terms an adjustment reaction or do they reflect an institutional neurosis which is to all intents and purposes more serious in nature? Irrespective of which diagnostic label one ultimately chooses, the need for psychotherapy is strongly indicated for patients

who are in the midst of adjusting to a new environment. Many professionals working in aged homes, may not be aware of the severity of such affective disturbances in residents, and as Slater and Roth (1969) point out, delay in such recognition hinders ensuring a positive outcome for newcomers to residential settings. In support of this statement, the writer refers the reader to review the profile of control group subjects.

What happens with respect to the cognitive variables? The author has argued throughout that the severe stress of institutionalization occurs in its most extreme form just after entering the home. There is a disequilibrium period in which mental disorganization ensues and for some residents it takes the form of almost total disorientation in time and place. Do these symptoms abate or do they become part and parcel of an insidious dementia? The term dementia implies a progressive and generally irreversible global deterioration of mental functioning and behaviour due to a destructive organic process. Looking at the symptoms of mental disorganization (a psychological measure on the PAMIE) which reflects the resident's level of confusion, we find a significant difference between the crisis intervention group and the other two groups at post-test and follow-up assessments (see figure 28). That is to say the residents within the CI group become less confused and are more able to make sense of their environment in comparison to members within the SA and control groups. In the latter groups general confusion prevails and the symptoms tend to get worse, with the control showing the greatest degree of confusion at the end of the third month of residency.

In crisis intervention, confusion is regarded as being antipathetic to healthy functioning and it is discouraged immediately. By making the resident focus on what happened in the recent past, the therapist

tries to help him/her gain cognitive awareness of the immediate situation through verbalization and ordering of all the aspects, including bringing into full consciousness those elements which may have been repressed or denied. By trying to get a coherent picture of what has been going on and is still happening, one's thought processes are made clearer.

In the SA and control groups no formal procedures were adopted to enhance cognitive functioning and perhaps the fact that this was not done explains the concomitant rise of confusion. It leads us to raise an important question as to whether a conglomeration of traumatic experiences can speed up an underlying predisposition towards dementia. There are many changes occurring in the organism at the time of old age. Busse (1969) has advanced two concepts to explain how one ages. The first, biological aging, refers to those genetic processes which are time-related but independent of stress, trauma and disease. His other category, secondary aging, refers to the effects from trauma and chronic illness, and it is to this alternative that we direct our attention.

Biological theorists studying aging at the cellular and sub-cellular level, propose that cumulative effects of trauma to individual cells eventually result in organismic dysfunction. Curtis (1966) claims that there is increasing prevalence towards long-term chronic disease, the etiology of which arises from cumulated insults to the organism.

The nature of the relationship between the psychological and pathological changes in cases of senile dementia and those found in normal elderly subjects has been recently investigated in the course of an enquiry in which a large number of psychiatrically ill subjects

and persons admitted to hospital on account of physical illness alone were tested with the aid of two psychological measures designed to describe their level of intellectual functioning and their competence in everyday activities in quantitative terms (Roth et al, 1967). A high proportion of those admitted with physical disease showed neither psychiatric disorder nor any obvious psychological deficit on clinical examination. In those patients who came to post-mortem, detailed pathological studies were carried out and this included a mean plaque count computed in each case from a total of 60 microscopic fields sampled from 12 sections of cerebral grey matter. The results suggest that the occurrence of senile plaques in patients with a wide range of psychiatric disorders and normal elderly subjects alike, arises from the fact that the cerebral degenerative process the plaque represents is closely related to a psychological change that cuts across diagnostic distinctions to some extent. It seems likely that the differences between well-preserved, mildly impaired and unequivocally demented subjects are of a quantitative nature, though the possibility that senile dementias are qualitatively apart in respect of some pathological change that remains to be discovered cannot be excluded. In other words, the clinical picture of senile dementia may become manifest when a certain threshold is passed by the degenerative process.

All pathological changes described in association with senile dementia - plaques, neurofibrillary change and granulovacuolar degeneration - have been found to a limited extent in well-preserved old people. What causes these underlying factors to take on clinical significance still remains a mystery. Perhaps accumulated life stresses and their effect on the biological system of old people require but one catalyst to set the degenerative process into motion. The effects of

institutionalization may be the stimuli which trigger off active dementia in the sample of people under investigation. If mental disorganization, (a symptom that results from entrance to an aged institution) is not adequately dealt with, global cognitive deterioration may ensue.

Psychological deterioration, a second order factor on the PAMIE scale comprising of the following first order factors

- (a) Mentally Disorganized/confused
- (b) Withdrawn/apathetic
- (c) Behaviourally deteriorated
- (d) Self-care dependent
- (e) Bedfast, moribund

was measured in accordance with the specifications laid down by the design. Results indicated that there was a significant difference between the CI group and the other two groups at each level of assessment. At post-test and follow-up assessments the SA and Control groups were more psychologically deteriorated whereas the CI group had made an adequate adjustment.

We shall now go on to discuss the social psychological findings of this study. Examining the variate of life satisfaction we find the following trends. There is a significant difference between the crisis intervention group and the other two groups at each level of assessment with respect to this measure (see figure 6). At admission to the various homes all three groups appeared to start out with similar scores of life satisfaction. At Assessment 2, both the CI and the SA group scores had risen, whereas the control score had dropped quite considerably. That is to say, both therapeutic groups demonstrated increased life satisfaction immediately after the cessation of treatment whereas

the control group demonstrated a lack of life satisfaction during the same time period. Simply removing the aged person from a stressful situation that he/she faced prior to institutionalization does not seem to help. Therapeutic intervention appears essential to facilitate a smooth passage into the institutional corridors.

At a follow-up assessment some six weeks later, the control group had depreciated more markedly whereas those members within the crisis intervention group had increased their life satisfaction steadily. There was little or no change at this assessment for members within the social attachment and activity group. They had maintained a position of positive morale which was more favourable than at the outset of the study. This was an unexpected finding since it will be remembered that this group approximated the direction of the control with respect to depression, i.e., they became more miserable and one would have expected a similar trend with respect to life satisfaction.

Chown (1977) defines morale as follows ...

Morale is the emotional component of a person's attitude toward his own life and may be defined as a reflection of his feelings about his past, present, and future. When such a broad view of morale is taken, it becomes synonymous with degree of satisfaction of life. It seems likely that morale will be related to the individual's assessment both of his own potential and of his career to date and that it will reflect the degree of concordance between his original hopes and aims and his achievements (p.672).

For many years it was accepted that activity represented adjustment (Havighurst and Albrecht, 1953). Many investigators have indeed

found that continued activity and high morale are correlated (Anderson, 1967; Kutner, 1956; Lipman and Smith, 1968; Maddox, 1965; Phillips, 1969; Tobin and Neugarten, 1961; Zborowski and Eyde, 1962), although Maddox (1965) did find that over a 7-year period there was some decrease in activity for most elderly people.

In contrast, disengagement theory suggests that aging people like to become less involved with the world and with social norms, and to be more interested and preoccupied with their own standards and philosophy of life. Sir John Hoby (1561) a tudor translator expresses the position with elegant melancholy ...

Therefore (me thinke) old men be like unto them, that sayling
out of an Heaven, behould the ground with their eyes, and
the vessell to their seeminge standeth styll and the Shore goeth:
and yet is cleane contrary - for the heaven, and likewise the time
and pleasures, continue still in their estate, and we with the
vessell of mortalitie flying away, go one after another through
the tempestuous sea that swalloweth up and devoureth all Thinges,
neither is it granted us at any time to come on shore again,
but alwaies between with contrary windes, at the end we breake
our vessell at some Rock (in Comfort, 1976, p.65).

Disengagement - a concept fraught with conflict, is neither simple nor an all or none affair. It is not entirely voluntary and in most cases the author would argue that the environment plays a considerable part in determining social withdrawal. There is now good evidence to suggest that voluntary disengagement is not harmful to morale, but that forced disengagement whether due to poor health, disability, widowhood, retirement or low income, does affect not only social interaction but also morale (Lowenthal and Boler, 1965;

Tallmer and Kutner, 1969). Following the implications of this argument, aged persons entering some form of institutional living whether they choose to or not, are in a process of forced disengagement. Therefore we would expect institutional residents to have lower self-esteem than people living independently (Pollack, Karp, Kahn and Goldfarb, 1962). The decision to enter such a home, entailing as it does the threat of loss of functional independence and admission of helplessness is the critical point.

The present study, in part, was designed to examine whether some intervention could retard the effects of forced disengagement thereby altering the expectation of increasingly poorer life satisfaction as one moves along the institutional path. Results of this study indicate that in both treatment groups this seems possible, with the therapeutic group, namely crisis intervention, continuing to make significant changes right up until the third month of residency. Perhaps the expected disengaged position, so typical within the institutional setting, need not be a foregone conclusion. In a stimulating or enriching environment there would be no need for it to occur and, furthermore, the author believes that most residents would not naturally choose this position as their first alternative. He is in agreement with Comfort's (1976) view of disengagement which states that ...

Disengagement in our culture is often, alas, sludgelanguage for being ejected, excluded or demeaned, and liking it - an attribute wished on the newly created old to plaster our guilt and provide a piece of jargon to excuse our conduct. Age-proof people will have none of it.

If "disengagement" were real, it would have to be optional.

In that case it would not be necessary to define it with a special

name - at any age you can opt out of what you have been doing, often because it is seen to be not worthwhile (p.65).

Because none of the homes under investigation had a specific reorientation program for its new residents, those elderly who were not given crisis therapy nor exposed to a social attachment and activity program were forced into the disengaged position. It was not surprising therefore to find that this group had the lowest score with respect to life satisfaction. The process of disengagement can be understood as being based on a simultaneous devaluation of attachments, so that the older person and his social milieu withdraw from each other in terms of the number of contacts and the strengths of attachment bonds.

The present research study has attempted to re-develop an attachment to a psychotherapist or volunteer so as to enhance the resident's ability to control and master the environment. Control gives the resident a sense of relief from the pervasive feeling of helplessness which has been created by the process of institutionalization. Ultimately, with the removal of helplessness, depression subsides and there is a concomitant rise in life satisfaction. In the final instance, it appears that the crisis intervention group is able to totally meet these objectives. The SA group improves slightly but there is some query as to whether these changes are long lasting.

Let us consider the results with respect to a measure of self-concept, namely the Osgood Self Evaluation Scale (see figure 20). the self-concept is the image the individual has of himself; it reflects his actual experiences and the way he interprets these experiences, his actual self and the way he interprets this self.

Given the stresses and losses that come with entrance to an institution, given the lack of respect shown to the elderly, given

their diminishing physical capacities and sometimes their diminishing cognitive capacities, it is only common sense to believe that in the absence of treatment, a resident's self-esteem should drop drastically during his/her stay in an aged home.

This hypothesis is not borne out by the research data. We find at the end of Assessment two, the control group demonstrated a slight rise in the score. This gain in self-concept sustained itself throughout the duration of the study. Despite the control group demonstrating the lowest score with respect to the variate of self-concept, it was nevertheless positive and against the common sense prediction. How do we explain this result? Bennett (1963) claims that the new resident is socialized into accepting the norms and values of his/her new environment. Implicit norms are that the home is immune from criticism and that the resident should present himself/herself in the best possible light so as not to offend others. Perhaps in attempting to do just this, the newcomer adopts a false self-concept. That is to say, there is a possibility that members within the control are indeed denying their own feelings of lower self-esteem, but that such denial is an appropriate and effective mechanism for adaptation at this point in their lives. Defence mechanisms perform an important function in permitting people, at any age, to maintain an adequate self-concept. At present, we have no sound basis for this belief and it can only remain a tentative hypothesis.

The crisis intervention group, however, demonstrated a consistent rise in self-concept which reflected the positive gains from psychotherapy. The SA group on the other hand, indicated that there was a rise in self-concept which, however, did not sustain itself, for at the end of the third assessment, there was a definite drop in self-evaluation.

Before commenting on the interpersonal behaviour of aged residents let us briefly review the literature with respect to interpersonal distance. The concept of personal space as an area or distance that a person ordinarily places between himself and other persons (Sommer, 1959) made its initial appearance in the 1930's. Since that time, however, it has received only sporadic attention and recent interest and research into interpersonal distance derives largely from investigations into territoriality and spacing patterns in infra human species (e.g. Ardrey, 1966; King, 1965).

Early conceptualizations of interpersonal distance in man directly paralleled those deriving from non-human species : personal space was defined as a stationary area surrounding an individual, having a regular format and boundaries (Horowitz, 1968).

Hall (1964) theorized that interpersonal distance of humans consisted of a series of concentric circles surrounding an individual. He proposed that the degree of intimacy and the particular function of relationships determined the zone in which types of interactions took place. Four zones were designated : intimate, casual-personal, social-consultative and public.

Sommer (1961) distinguished human territory from animal territory in that human personal space has :..... "no fixed geographic reference points, moves about with the individual, and expands and constructs under varying conditions (p.247).

He demonstrated that such territories exist and vary on the basis of interpersonal stimuli and situational constraints (Felipe and Sommer, 1966). Similarly, Little (1965) regarded the distance an individual placed between himself and others as being more accurately represented by a set of "non-concentric, fluctuating globes" (Duke and Nowicke, 1972).

Horowitz (1968) identified two facets to the interpersonal distance phenomenon : stationary space, with a relatively fixed boundary, and "portable space, which was seen as surrounding and moving about with the individual. This mobile area was labelled the "body-buffer zone" and was seen as deriving from the externalization of body concepts and feelings. The function of the "body buffer zone" was to protect an individual against personal threats to his emotional well being and to deal with the type of intrapsychic factors which Fisher and Cleveland (1958) score as "boundary", "barrier", and "penetration" on the Rorschach and Holtzman inkblots.

What happens within aged residential settings? Do newcomers actually put up barriers around themselves to limit interpersonal relationships from developing? Is there less friendliness and more hostility toward others? Results arising from the present study indicate the following. We find a significant difference between the crisis intervention group and the other two groups with respect to the variates of depth, warmth, motivation, co-operation and spontaneity at each level of assessment (see figures 21-25). The three groups started out with similar scores which however changed rather dramatically after the cessation of treatment. Both the CI and SA groups demonstrated an increase in interpersonal relationships with, once again, the CI group showing the greatest improvement.

The degree of acquaintance between individuals influences interpersonal distance responding. A consistent relationship between interpersonal distance and liking has been established by a number of researchers (King, 1966; Lett, Clark and Altman, 1969). Exposure to both forms of treatment therefore is likely to reduce one's social barriers and encourage outward responses of self-expression.

In contrast, when individuals are fearful of, or experience, negative contingencies in interactions, this generally leads to an increase in inter-personal distance (Horowitz, 1968). Data on eye contact and gaze avoidance parallel these findings (Mehrabian and Friar, 1969). Exline and Winters (1965) found that when subjects were negatively evaluated by a hostile interviewer they avoided looking at the experimenter more than a control group of subjects who were not negatively evaluated.

Looking at the control group at Assessment two, in certain instances there was a reduction in interpersonal behaviour supporting the above argument. However, there were occasions where little or no change was evidenced. At the follow-up assessment, the CI group had continued to make significant improvements whereas the SA group demonstrated a marked decline in interpersonal functioning and had tended to increase their social distance. Perhaps this was linked to an increase in the depressive symptomatology reported. One may hypothesize that depressed individuals will exhibit a greater interpersonal distance towards others than non-depressed persons. Data on investigations of interpersonal distance and locus of control suggests additionally that differences between depressed and non-depressed persons will be most evident in interactions with unfamiliar stimuli. Duke and Nowicki (1972) provide evidence for a positive correlation between interpersonal distance towards a stronger and increasing depression.

Not much fluctuation is seen with respect to interpersonal behaviour in the control group at Assessment 3. Most of the scores have remained the same with the exception of one or two variates. No supportive evidence with respect to social distance and depression was forthcoming in this group, since one would have expected the control to demonstrate the greatest level of interpersonal distance since participants in this

group were the most depressed at this stage of the proceedings.

Bennett and Nahemow (1965) define social adjustment as ...

... "fitting oneself into an ongoing social situation" including "social integration", which refers to "participation in activities; "evaluation" which includes "... the concept of morale insofar as it reflects an evaluation of the social environment"; "conformity" which is ... behaviour enacted in accordance with social norms" (p.47).

It is their belief that residents of homes are expected to participate in activities, develop informal relationships, obey rules and do very little complaining. Social integration as indicated by participation in formal and informal activities is generally the major criterion of adjustment.

The present research focused on the development and evaluation of two treatment programs for new residents in order to facilitate the adjustment process. Looking at how successful it has been, with respect to the variate of social involvement, (see figure 26), we find that there is a significant difference between the crisis intervention group and the other two groups, at each level of assessment. Initially both experimental groups become more socially involved after the cessation of treatment. At the follow-up assessment, once again the crisis intervention group have made substantial gains whereas the social attachment and activity group have become less involved and scores moved in the direction of the control. Not having been exposed to any form of intervention seems to be detrimental for residents since they do not socialize adequately and tend to adopt an isolated position (see control group result). Social isolation is defined by Tec and Granick (1960)

as "absence of specified role relationships which are generally activated and sustained through personal interaction". The more isolated one is, the less attachments one makes, and as we have already demonstrated, unless one gains meaningful feedback from social interactions one can effect no personal change. A helpless position ensues, and concomittant depression results.

In concluding the discussion with respect to the psychological variates under investigation, it has become painstakingly clear that the three treatment groups adjusted in different fashions. The crisis intervention group appears to differ more from the control group than the social activity group. In many variates, it shows reverse trends opposite to that of the control. As we have shown throughout the preceding discussion, these directional trends in all instances point to the positive pole in the adjustment-maladjustment continuum

In all treatments, the initial variate means were not different but diverged consistently from Assment 1 to 2 and 2 to 3. More variates continued to diverge from Assessments 2 to 3 than reverted back towards Assessment 1 levels.

The implications of these findings will be discussed at great length in a later chapter.

8.2 Discussion of the Suitability of a Dialectical Analysis with Respect to the Present Study :

In the introduction, the author raises the question as to whether it is possible to examine adjustment to an aged home in terms of a dialectical model. Biological, psychological, socio-economic, social and environmental factors play a leading role in determining how one ages. Those people who are forced to decide upon institutionalization as their last alternative experience disequilibrium with respect to some of the above-mentioned variates. The decision to go into a home marks the beginnings of what is known in dialectical terms as the thesis.

Upon acquiring institutional status, the resident faces immediately both explicit and implicit demands to adjust to the norms, values and expectations of the particular home in question. In most cases, the resident is unable to meet all of these, and a state of conflict is created, whereby both the home as well as the newcomer struggle to accomodate to each others needs. This conflict often creates an adjustment reaction characterised by affective disturbance, psycho-social withdrawal, and in certain instances, cognitive disturbance exists as well. This characterises the antithesis. Some of the needs of the home are that members obey rules, co-operate with staff and in general accept the norms and values associated with corporate living.

Bennett (1963) claims that the following are explicit statements of some implicit resident norms.

- (1) A resident should neither criticise The Home nor complain about it.
- (2) Not only should he not criticise The Home, he should praise it and come to accept it as his home.

(3) A resident should keep active and busy.

(4) A resident should not argue with others in The Home. If possible he should avoid intimate contact with others and only observe formalities, which consist mainly of saying "good morning" or "good evening" (p.22).

According to one administrator,

Residents are expected to behave as ladies or gentlemen, They are expected to be courteous and say 'hallo' to all, including staff members. They should be clean and dress nicely ...

The well adjusted individual is part of the group. He is neat in appearance, because the others will be critical of sloppy people (ibid, p.121).

For acceding to these demands the home provides shelter, care, and attention, and a refuge from stress factors which have lead to the resident's application for admission in the first place.

There is continuous dialogue between the two parties in an attempt to resolve the specific demands on either side. Unless the resident makes a series of adaptations in the biological, psychological and socio-cultural arenas, his/her stay in an aged home is bound to be plagued with increasing levels of conflict, which in the final analysis produces maladaptation. The synthesis characterises the struggle by both parties to accept the predicament that they face thereby creating the climate for adjustment to ensue. Synthesis can be defined as the composition of oppositional parts into a more complex whole. It is not merely the choice of one oppositional demand over the other, but the dialectical combination of thesis and antithesis into a higher stage of truth.

Dialectical psychology is committed to the study of actions and changes and is primarily concerned with how individuals and groups overcome internal and external conflicts created by crises. Consequently it reinterprets crises and contradictions in positive terms. For dialectical psychology it is important to find out how challenges are recognized and how questions are asked rather than how problems are solved and how answers are given. In emphasizing the social basis of human beings, the interaction between two persons in the form of dialogues provides the prototypical example for such explorations.

Riegel (1976) has outlined the pre-requisites of a dialectical psychology. Firstly, he claims that a dialogue has temporal structure. The speakers alternate in their presentations and each successive statement has to reflect the one immediately preceding it. Each utterance must be consistent with the proponent's own views and must represent equally consistent or systematically modified reactions to all statements made by the opponent. Moreover, each utterance should reflect issues of the topic or theme which are pre-supposed but not necessarily openly expressed in the dialogue. The relationship between the aged newcomer and the representative of authority in the home, be it a nurse, social worker or administrator characterises the continuous nature of dialogue. Dialogues also exist with other residents, and both ultimately have the function of providing the new resident with acceptable guidelines for adjustment into a foreign environment.

If such a reflective co-ordination did not take place, the dialogue would degenerate into alternative monologues in which each speaker would merely follow up on his/her earlier statements without reacting to the opponent's elaborations. If this were the case, no socialization could take place.

How does socialization in fact occur? According to Riegel (1976) the language between the participants couches the values and norms which outline the direction of interaction and ultimately the prerequisite for adjustment. The two speakers might represent quite different social groups with very different orientations, preferences and goals. Communication between them is possible only because the groups to which the speakers belong are part of the same society and thus share many properties of a more fundamental communication system.

In the relationship between the representative of authority in the home and the aged newcomer, complicated transactions occur. The caretaker has to speak, direct and prevent harm from coming to the resident, but he/she has to also listen and change his/her activities according to the demands of the newcomer. The synchronization of these two time sequences, that is, the changes and development of the resident, and the changes and development of the caretaker is of central importance in their dialogue and ultimately reflects whether healthy adjustment ensues. By their very nature, these two systems, i.e., the staff system and resident system are out of phase with each other, which in turn creates tension and conflict. According to Riegel, Datan and Reese (1977), this leads to development. A dialectical theory of human development focuses on the simultaneous movements along at least the following four dimensions, (1) inner-biological (2) individual-psychological (3) cultural-sociological, and (4) outer-physical. The progressions within one particular and two different dimensions are not always synchronized. Whenever two sequences are out of step it is said to create a crisis. However, crises should never be exclusively negatively evaluated. Many crises represent constructive confrontations leading to new development.

While the author accepts this point of view for earlier stages of

development, there is some doubt as to whether one can simply leave elderly people who have entered their last home to simply negotiate this life crisis successfully. Looking at the control group at post-test and follow-up assessments, this study reveals that unresolved crises create deterioration in psychological and social variates which is no longer functional. No significant changes were reported with respect to biological variates. However, this may simply be a result of unsuitable measures that were insensitive to small changes.

Without active intervention - a position of helplessness exists which could lead to premature death. N.A. Ferrari (1962) found the following in a doctoral thesis carried out in the United States. Fifty-five females, over 65 years old and with an average age of 82 applied for admission to an old age home in the Midwest. Ferrari asked them upon admission how much freedom of choice they had felt in moving to the home, how many other possibilities had been open to them, and how much pressure their relatives had applied to them to enter the home. Of the seventeen women who said they had no alternative but to move to the home, 8 died after four weeks in residence and 16 were dead in 10 weeks. Apparently only one person of the 38 who saw an alternative died in the initial period.

Although no supportive evidence was found in the present study, many of those people left to negotiate the crisis of institutionalization unaided were virtually psychologically dead, at three months after admission.

It is interesting to note that this position is recognized within dialectical theory itself

Crises originating along the inner-biological dimension, such as illness, incapacitation, or death are nearly synchronized with

individual-psychological events and therefore create critical problems for the persons affected. Nevertheless, successful synchronization constitutes the goal in these and many simpler situations, and whenever a crisis is resolved, a synchronizing reinterpretation has taken place. Crises could be prevented if synchronization could be achieved prospectively.

(Riegel, 1976, p.693).

Implicit in this quotation, is the idea of enhancing synchronization. Although actual death for these theorists is meaningful, there is a definite realization that unless some kind of active intervention is applied to prevent arrested development - helplessness and "psychological death" are strong possibilities. In the present study, we found that through the use of crisis intervention strategies we were able to reverse the helpless position and enhance further development.

The attraction of the dialectic method with respect to this study is its comprehensive assessment of adjustment variates. It not only considers the aged person on a psychological basis, but looks equally at biological and socio-cultural criteria. By so doing it places the newcomer in the context of the real life situation. Each subject has been assessed in terms of strengths and weaknesses, with the measure of biological, psychological and social function being of crucial significance.

One hypothesizes that a change in one area produces concomitant changes in other areas. Taking those residents within the crisis intervention group, it was found that improving their psychological state had positive 'spill over' effects in terms of certain social parameters, namely community and family involvement. However, no change was found with respect to biological variates. Possible

reasons were that the measures employed were too unsophisticated to register small biological changes that occurred. Alternatively the time span employed within the present research design possesses severe limitations for a dialectical analysis. In three months, perhaps even with sophisticated instruments, it is not possible to depict changes within physical variates. A follow-up carried out after one year would give more meaningful results.

Dialectical contributions to gerontology are still in their infancy and in the final analysis, a dialectical interpretation of human development viz a viz aging remains a goal to be fulfilled. Much work has to be done in theory methodology, and, last but not least, in the application of dialectical thinking to research, education and social praxis.

8.2 Discussion of Therapeutic Outcome - With Respect to Present Study

In broadest terms, the enterprise called "psychotherapy" encompasses a person who has recognized that he is in need of help, an expert who has agreed to provide that help, and a series of human interactions, frequently of highly intricate, subtle, and prolonged character, designed to bring about beneficial changes in the patient's feelings and behaviour that the participants and society at large will view as therapeutic.

Strupp (1973) claims that, as a scientific discipline, modern psychotherapy must insist on a public or intersubjectively verifiable outcome ...

..there must be some way of documenting the occurrence of change, difficult and fallible as such a demonstration may turn out to be. There is no need to define change in restrictive terms, as behaviourists have done, but it is necessary to stipulate that

- (1) change must be demonstrable;
- (2) it must be relatively permanent; and
- (3) it must be attributable to the interpersonal transactions between patient and therapist.

(p.263).

Although these pre-requisites are relatively straightforward, very few people have actually managed to put them into practice, and the failure to do so has been a major factor for the continuing controversy concerning the effectiveness of psychotherapy as a treatment modality. The field has been plagued by prolonged and fruitless controversy as to whether psychotherapy "works", is "effective" or does any good.

Only during the last two decades have there been systematic attempts

to firstly assess patient changes over time, and secondly, link these changes to particular therapeutic operations. Because of the enormous clinical, technical, and methodological difficulties inherent in these tasks, progress has been slow, and there are as yet few if any studies that are immune from criticisms, usually on numerous grounds.

It seems to all intents and purposes that empirical research must be the final arbiter of the controversies besetting this area of investigation. Apart from the problem of assessing changes in the patient and determining whether a change has been for better or worse, there is no task equal in importance to an analysis of what the therapist does. It is obvious that the therapist attempts to change behaviour; influence one's thoughts about oneself and others, or set into motion processes that may result in change. He becomes effective through his personal interaction with another individual who at least on some level desires change and is motivated to seek it. To complicate this issue even further, it becomes necessary to make a distinction between the therapist's personality and his actions, between what he is and what he does. In practice, the two sets of variables necessarily fuse and it becomes extraordinarily difficult to disentangle their respective contributions to process and outcome.

Is change produced by a set of techniques (namely crisis intervention) so that it makes little difference who administers them providing one follows the specified guidelines? Alternatively, are techniques inconsequential? Is not change simply produced by a healer who exerts a powerful charismatic effect on individuals who seek his help? According to Strupp, 1973; Garfield and Bergin, 1971 and Gurman and Razin, 1977, most therapeutic procedures fall between these two poles : they are neither totally independent nor totally dependent on the person using them. They are in all likelihood potentiated or diminished by

the therapist's personality as well as the situational context in which the transaction occurs.

From this brief introduction it is hardly surprising to find that confusion continues to flourish at all levels. The fundamental problem which has proved so utterly refractory is that we are trying to assess the outcome of exceedingly complex human interactions. To try and make a scientific exercise out of this task we ask ourselves :

Does a set of specifiable operations have a specifiable outcome? In other words, we try to ascertain whether the therapist's interventions have produced a measurable effect on the patient with the proviso that the changes must be relatively permanent and stable.

Changes resulting from psychotherapy are usually classified under two main rubrics : (1) feelings and cognitive changes, and (2) behaviour. The former are generally assessed by standardized self-report measures; the latter by ratings of the therapist, sometimes complemented by external judges such as independent clinicians, room-mates, spouses, etc. Because of the lack of agreement on criteria of outcome and the inevitable intrusion of value judgements, the assessment of therapeutic outcomes has remained one of the major obstacles to progress.

There are the changes that have nothing to do with the therapy per se but simply reflect that of a placebo. Shapiro (1971) has demonstrated that placebo effects are by no means restricted to drugs but are a pervasive phenomenon in fields as disparate as medicine and psychoanalysis. Eysenck (1952, 1965) has termed it spontaneous remission.

After 25 years and much debate, it is disheartening to find that there is still considerable controversy over the rate of improvement in neurotic disorders in the absence of formal treatment. The issue continues to

be of major interest because spontaneous improvement is presumed to confound the success rates that are attributed to participation in psychotherapy. Eysenck reasoned that any form of psychotherapy worth its salt must exceed the baseline defined by "spontaneous remission" or face a verdict of

In summary, we see that the evaluation of psychotherapy is by no means an easy task and in most cases it is plagued with inconsistencies, fruitless polemics and a lack of adequate knowledge. However, the search for greater awareness and more satisfactory measures of outcome proceeds in many areas. Of late, geriatric psychiatry is beginning to take stock of what is useful, and evaluation of psychological mental health programs for the aged are being made more often. In the section that follows we shall be looking at an evaluation of therapeutic attempts in custodial settings paying particular emphasis to the present study.

To reiterate, the aim of the study was to develop and then test two treatment programs to see whether they supplied the aged newcomer with the means to minimise the adjustment reaction experienced upon being institutionalized in residential setting. The two treatments were Crisis Intervention and Social Attachment and Activity.

In response to adverse circumstances or to specific traumatic events such as an unforeseen change in living arrangements, many older individuals experience transient or more enduring adjustment reactions characterised by a variety of emotional and physical disturbances the most prominent of which is anxiety, with all its psychological and physiological components. Fear sometimes to the point of panic, perplexity, emotional lability, tearfulness, feelings of helplessness and depression dominates the psychological symptomatology. Tremulousness, muscular

tension, a rapid heart rate, subjective feelings of shortness of breath, epigastric discomfort and disturbed sleep characterise the physical side of the syndrome.

Thus, to all intents and purposes, it was our specific objective to try and minimise these symptoms so as to enhance healthy functioning. A pre-test post-test follow-up design was employed to determine whether symptoms abated immediately after the cessation of treatment (lasting five weeks) and whether these changes were of a permanent origin.

The two treatments, CI and SA, were found to have an effect on adjustment different to a control group. The CI group being most markedly different, causing opposite trends in most of the variates in comparison with the control group.

Those individuals exposed to crisis intervention techniques in this study showed the greatest reduction of symptoms associated with the adjustment reaction and were coping well at three months post-admission. Short-term psychotherapy, namely crisis intervention, was chosen specifically because of its close theoretical links with the psychiatric concept of transient situational disturbances (now known as an adjustment reaction). It will be remembered that crisis is an upset in a steady state. Certain events may pose an actual or potential threat to fundamental need satisfactions and upset the equilibrium. Events that threaten these needed satisfactions are defined as emotional hazards. They may relate to changes in the physical surroundings, social sphere, or biological function of an individual. Whether or not a given event constitutes a hazard depends both on the event and on its meaning to the individual.

Coming into an aged home is the emotional hazard which triggers off a crisis

It is provoked when a person faces an obstacle to important life goals that is for a time insurmountable through the utilization of customary methods of problem solving. A period of disorganization ensues, a period of upset, during which many different abortive attempts at solution are made. Eventually some kind of adaptation is achieved, which may or may not be in the best interests of that person or his fellows (Caplan, 1961).

Caplan (1964) described four stages of crisis : (1) an initial rise in tension calling for the habitual problem solving responses, (2) a further rise in tension and a condition of ineffectiveness; (3) a still further rise in tension accompanied by mobilization of external and internal resources; and (4) if all fails, a last stage of a major breaking point with disorganization of the personality. The latter stages are characterised by mounting anxiety and depression and by a sense of helplessness (being trapped) and hopelessness. Most authors agree that the acute stage of crisis lasts no longer than four to six weeks after onset.

Perhaps the success of our results can be attributed to bridging the hiatus between theory and technique. Alternatively, one may hypothesize that the amenability to change is produced by heightened emotional arousal. The directive nature of brief therapy often provokes strong feelings in the patient. Furthermore, the time limitation on the therapy keeps the sessions at a higher pitch. An area of research important to the understanding of brief psychotherapy involves the study of attitude change under heightened emotional arousal.

Saltzman et al (1976) found that individuals who drop out of therapy in the early sessions are those who experience relatively lower levels of anxiety. In their review of the relationship between affect

and change in therapy, Luborsky et al (1971) concluded that almost any affect is better than no affect and patients who are anxious and depressed at the beginning of therapy are the ones more likely to benefit from therapy. The heightened state of arousal resulting from the patient having just recently experienced an emotional crisis may make the patient particularly amenable to directive intervention.

Some of the most ambitious intrainstitutional intervention programs have been designed just to overcome the discrepancy between potential and actual functioning in aged citizens. Such an attempt to rehabilitate long-term nursing patients was undertaken by a co-operative group of leaders in rehabilitation medicine and public health in New York City (Kelman, 1962). Matched samples of randomly assigned aged patients were compared before and after one year of intervention, with change criteria consisting of levels of function in ambulation, dressing, feeding, care of toilet needs and transfer skills. An individually planned therapeutic program for each patient was devised with one experimental group treated by a comprehensive rehabilitation team in the nursing home and the other transferred to an established rehabilitation hospital. Their results showed no difference between the experimental and control groups and no significant change with any group. Despite employing unusually extensive and capable resources, the modest goals were not realised.

Another stern effort to overcome excess disability was undertaken in a home for the aged (Brody et al, 1971; Kleban and Brody, 1972; Kleban et al, 1971; Brody et al, 1974). Thirty-two pairs of women residents in their eighties were evaluated for individual areas of excess disability such as mobility, personal self-care, and social and family relationships. Specific goals for each person were determined

by an extensive interdisciplinary team on the basis of history, observation and meeting with the family. The staff worked intensively with the experimental group, while the control group received the usual institutional care. Evaluations of change were made after one year by staff and personnel and outside observers who depended on their information from chart and other staff notes. Improvements were noted in both groups but somewhat more in experimental subjects. Nine months later, however, the groups were no longer distinguishable and both showed decline, despite the fact that they "... continued to receive ... the normal high level of care of the sponsoring institution".

Will this happen to members of the present study? Only time can tell. It certainly is a possibility. However, it is painstakingly clear from the results that subjects who enter aged residential settings do benefit significantly from crisis intervention in that it reduces the affective, cognitive, social and behavioural disturbances precipitated by admission. Furthermore it encourages individuals to make a strong attempt to re-introduce themselves to mainstream community life and, at the same time, it improves family relationships. Immediate gains from treatment seem to be internalized adequately as this group continue to make significant improvements in all areas at three months post-admission.

A serious methodological problem in outcome studies of crisis intervention is the mobility of the population resulting in loss of sample. Lowry, Wintrob, Borwich, Garmaise and King (1971) reported that nearly half of their follow-up study could not be fully interviewed because they died, moved, or had given false names. A second factor affecting adversely influencing sound outcome research in crisis therapy is the difficulty of sample specification. Crisis intervention techniques are recommended for any client in crisis, regardless of his or her typical

adjustment and situational pressures.

Outcome research in crisis-oriented psychotherapy is one of the most difficult undertakings. The patients receiving treatment in crisis settings are extremely heterogeneous and defy classification into neat research designs. In addition, this population as a whole tends to be quite transient and difficult to locate in follow-up. Consequently, the literature is scarce and generally flawed. Studies of outcome of crisis intervention therapy, of course, also suffer from the same problem inherent in other outcome studies (e.g. differential results depending on the type of patients used and outcome measures employed).

With respect to the outcome of results in the social attachment and activity group we find the following : immediately after the cessation of treatment, that is to say at the post-test assessment, there was a general improvement in the resident's level of functioning. Scores on measures of depression, somatic concern, anxiety, guilt feelings, hostility and life satisfaction all improve. However, this improvement is short-lived.

The comparison (between Assessment 1 and 3) x (between treatments) tests the null hypothesis that the direction or slope of adjustment between Assessment 1 and 3 is the same in the CI and SA groups. This hypothesis is rejected in 24 variates at the 0.5% level, 1 at the 1% and 6 at the 5% level. This indicates strongly that the treatments differ in their effect on adjustment and observing that the SA group agrees in direction with the control, the CI treatment is the outstanding one.

In reviewing intervention programs within institutions, Lieberman (1969) feels that any change introduced will lead to some sort of nominal improvement because of a "Hawthorne" effect in which any alteration in a boring and repetitive situation may lead to increased behavioural output.

A breakdown in the heating system of a particularly bad nursing home has been observed to lead the usually withdrawn and isolated patients to huddle together for warmth, and thus to a general increase in "social interaction" (Kahn and Zarit, 1974). In this instance, an additional negative stimulus resulted in the same kind of "improvement" reported with more benevolent planned changes.

The Hawthorne effect has produced a rash of faddish treatments exemplified by such names as "re-motivation", "reality orientation" and "reality therapy" (Barnes, Sack and Shore, 1973). These programs are characterised by increasing the stimulation and attention paid to patients and may produce some non-specific trivial Hawthorne effect response. Staff are likely to feel much better about administering these programs because they are at least doing something, but from the patient's viewpoint, they do not appear to have any substantial effect.

Do we regard the results of the social attachment and activity program employed within this study in a similar light? Methodologically speaking it is possible to argue that improvement has nothing to do with the content of the therapy per se, but simply reflects the development of a relationship involving social attachment between client and therapist, at a time in the aged resident's life when he/she is most needy. Interpersonal relationship replaces the set of techniques which were previously held responsible for growth with qualities of the therapist's personality being important. The problem of analysing the components of the interpersonal relationship is as urgent (as well as difficult) as that of specifying the influence of particular techniques.

There is ample evidence (Truax & Carkhuff, 1967) that any "good" human relationship - i.e. an interaction characterised by understanding,

acceptance, respect, trust, empathy, and warmth - is helpful and constructive. If such a relationship is provided by one person (volunteer) for another (resident) who is unhappy, demoralised, defeated, and suffering from the kinds of problems which our society has diagnosed as requiring the services of a specialist in mental health, the outcome will generally be therapeutic, provided the recipient is able to respond to, or take advantage of, what the therapist has to offer. Bergin (1971) believes that psychotherapy begins precisely at the point where a patient cannot profit from a good human relationship, and the professional is needed specifically to help engineer one.

The above example typified the condition of the aged resident at the time of admission. However, it appears from the results of the present study that although a pre-requisite for positive outcome, the interpersonal relationship as a therapeutic force is not sufficient and it would appear that without the therapist's technical intervention positive gains that are made cannot withstand the pressures of the environment once support is removed (see results of SA group at Assessment 3). The author believes that the results from this experiment have important ramifications for the theory of attachment to aged newcomers. We stated earlier that the only way to meaningfully rehabilitate an aged newcomer to a residential home is to facilitate a process whereby strong affective reinvolvements are enhanced. Simply doing this on a one to one relationship, by being supportive, warm and understanding seems doomed to failure. It appears that one is required to involve oneself directly with negative feelings associated with institutionalization as well as to actively plan ongoing strategies to enhance development. Active therapeutic involvement therefore appears to be the crucial variate that produces significant changes in aged residents.

Finally one may argue that personality variables of the therapist influence the final outcome. Therapists, like patients, obviously differ on as many dimensions as one cares to mention - age, sex, cultural background, ethnic factors, level of professional experience, psychological sophistication, empathy, tact, social values, to name but a few.

Among the therapist variables that have been subjected to quantitative research are : the therapist's personal adjustment (often measured by a standard personality test); "the facilitative conditions" already mentioned, (warmth, empathy and genuineness); the therapist's professional status (professionals versus non-professionals or paraprofessionals); sex, age, socio-economic status, ethnicity; and the therapist's social and cultural values.

It has frequently been mentioned that the effective therapist must be able to instill trust, confidence, hope and to strengthen the patient's convictions in his or her own strength. Yet real as these variables undoubtedly are, they likewise have eluded quantification. It is becoming increasingly clear that single therapist variables, except perhaps for glaring defects in the therapist's personality, are not likely to provide the answers sought by researchers and clinicians; instead a combination of therapist attributes appears to form an integrated Gestalt, to which the patient, others things being equal, responds positively negatively, or neutrally.

In summary, to produce positive outcome in strategies devised to aid in the adjustment of newcomers to residential settings, it appears that one requires active involvement on the part of the therapist. The application of effective techniques in dealing with hostile projections together with direct planning for possible future setbacks is crucial. The use of oneself in a meaningful relationship to provide feedback to the

resident seems highly appropriate. To have a therapeutic impact on the patient, the therapist's personality must have distinctive stimulus value or salience - he or she can never be an impersonal technician nor can he or she apply therapeutic techniques in a vacuum. Ultimately, empirical verification of one's claims of success must of necessity be the final arbitrator if we are to avoid the Hawthorne effect. In conclusion, we continue to be optimistic that research will lead us to be more and more helpful to the many suffering aged newcomers who seek relief from psychological distress associated with the institutional plight.

8.3 Discussion of Results with Respect to the Control

Undoubtedly of the three groups under investigation, this group does the worst. Between Assessments 1 and 3, there is a marked deterioration in most variates (see Graphical Interpretation of Results). It is reputed that once the older person actually enters the home, he/she enters a period of acute disequilibrium lasting 1 or 2 months and then an initial adjustment is made (Tobin and Lieberman, 1976). Results of this study do not support the fact that an adjustment is made so soon as it appears that members of the control are by no means settled by the third month of residency. In fact, they appear to be deteriorating and show signs of what is known as the institutional neurosis (Barton, 1959). It is an illness of the inmates of institutions which is caused by the institution and can occur in places where people are removed from society, † live in a rigid closed-off community. Loss of contact with the outside world, and erosion of the personality by the overpowering control exerted by the institution are important factors in the production of this disease. The inmate becomes over-dependent, does what he is told because this is the only way to avoid trouble, loses initiative and interest and becomes one of a group of automatons. His appearance often demonstrates the effect the institution has had upon him; his face loses much of its expression, the head is held slightly bowed and the arms held semi-flexed with the hands closed.

It would appear that failure to provide positive intervention procedures may have harmful effects which add to the psychopathology. This view has been developed by Gruenberg (1967, 1969) in his description and analysis of the social breakdown syndrome. He differentiates two types of symptoms in psychoses : those that are the direct consequences

of mental disorder, and those that are secondary complications due to our harmful response to the primary disorder. It is the latter, characterised by such behaviour as withdrawal, self-neglect, and dangerous behaviour, that he terms the social breakdown syndrome.

The social breakdown theory was initially developed to help explain the genesis of mental disorder in a general population. It is here offered as a sensitizing model, which explains something of the peculiar relationship between the elderly person whose social system is contracting and the broader social environment within which he lives. We shall argue that the probable consequences of social reorganization for the elderly is the creation of a basically negative cycle of events in which behaviours and attitudes toward the self develop; the wider society and ultimately the old person himself, defines these negatively and regards this behaviour as incompetent.

Gruenberg (1967) describes a series of pathogenic steps in the evolution of the social breakdown, such as labelling and extrusion, which confirms the individual's belief that he is "not quite right", relieving him of responsibility in an overtly sheltering hospital environment; and compelling isolation by cutting him off from his family ties, and compliance by learning the hospital rules and, finally, by identification with his fellow patients and by acquiring their sick role of decreasing ability to carry out ordinary social exchanges and work tasks.

Gruenberg describes these patterns of disordered social functioning as occurring independently of the particular type of mental disorder (1967). He believes that clinical evidence indicates that they are

preventable by maximising the patient's responsibility for himself and by positive expectations, but that once developed it is more difficult to reverse the process

According to Kahn (1977), the recognition that there is a distinction between the primary mental disorder and the symptoms resulting from our management procedures must be considered as one of the central issues in considering future mental health programs for the aged. Failure to be aware of this distinction can lead to confusion of cause and effect in evaluating mental status and type of care needed. Thus, a mentally deteriorated resident of an institution will be characterised as so impaired that he requires total institutionalization when it was the institutionalization that fostered the deterioration in the first place. In other words, the symptoms associated with the crisis of being institutionalized may well develop into long-term serious effects which, to all intents and purposes, impede healthy adjustment. The control group are at particular risk of this happening, and they must be helped through the transitional acute period with minimal negative effects. All people and objects from the former world that are incorporated into the new institutional world become anchors for the new resident. Family and workers, as well as personal belongings that have special meanings offer continuity. People and things that give continuity can off-set some of the initial sense of abrupt change but the balance is tipped toward what the newcomer experiences as unpleasant because of having to learn new rules and to puzzle out the attitudes of a new environment when cognitive and perceptual functions may be weakened by age and anxiety.

Once the initial impact of entering and living in the institution has been weathered, the new resident can go beyond merely accommodating to the foreign world. A rewarding and life-enhancing adaptation can be

achieved within the constraints of congregate living if the environment is sufficiently flexible and individuated. If a range of life-styles is actively encouraged, the heterogeneous population of residents play out the diversity of their idiosyncratic selves. Efficient operation obviously conflicts with maximum development of a flexible and individualizing environment. But if human losses are to be minimized, the struggle must be to help each individual express those aspects of self that yield satisfaction in independent living.

The results of the present study have indicated that members within the control group adopt or alternatively are forced to adopt a helpless position which then precipitates a depression of quite severe magnitude. Unless we are able to reverse this situation fairly rapidly, psychological death occurs. While it is true that eliminating the noxious conditions of existence will help create a benign environment, and while liberation from functional ethics will legitimize the creation of new options for action, the person must experience the source of his own action, the locus of control as resting with himself.

The externalization of control and decision making power mitigate against the maintenance of personal strengths, for it places the responsibility for action outside the individual. Experientially, one is left with the rhetorical question 'Why act, why initiate if it doesn't make any difference, if the real power to determine my fate lies outside myself?

The author would like to draw the attention of the reader to the case history of Mr. J. (see appendix) a control group subject who demonstrates many of the features discussed above.

CHAPTER 9

Implications for Clinical Practice.

Old people are not to be pitied.



**Old people are you and I
grown up.**

9.0 Implications for Clinical Practice :

Our investigation of the process of becoming an institutionalized old person has made it amply clear that older people are likely to undergo profound psychological and social alterations immediately after they become institutionalized. Presumably the process starts after they accept the reality that they will soon relinquish residential independence for the rest of their lives and culminates in a severe adjustment reaction which is known as the first month syndrome. As the newcomer separates from independent community living and intimate others, his attention begins to shift to the gains that can accrue from becoming institutionalized - principally care, people and activities. The meaning of losses connected with giving up independent living is separation; the experience is that of being abandoned, and reaction to it is extreme. Increasingly the person becomes cognitively constricted, apathetic, unhappy, hopeless, depressed, anxious, and less dominant in relationships with others

The severe stress of institutionalization occurs in its most extreme form just after entering the home, when the old person first has to sleep in a bed foreign to him, adjust to the idiosyncracies of a room-mate, live in a congregate environment, and learn the positive and negative sanctions of a new social world. The manifestation of the first month syndrome for some residents takes the form of almost total disorientation in time and place; for others, affective disturbances such as deep depression; and for others, rather bizarre behavioural symptoms. The first month is a period of continual ups and downs for some residents, whereas for others, there is immediate disorganization followed by an upswing and then a stabilization at a level of functioning that is somewhat

worse than their pre-admission level.

(Lieberman and Tobin, 1976, p.123).

The above description has been empirically verified as a definite clinical entity by the present study. In support of this claim, the reader is asked to examine the outcome of the control group over a three month period. Whereas most authors believe that this acute disequilibrium lasts for one to two months when an initial adjustment is made, the present research shows that in the absence of direct therapeutic intervention, members of the control group have not as yet come to terms with their new environment.

Unless the negative feelings such as fear of engulfment, restlessness, and disorientation are dealt with specifically, the affective disturbance associated with the crisis of institutionalization is likely to develop into more serious long term effects. These are namely, depression, unhappiness, intellectual ineffectiveness because of increased rigidity and low energy, negative self-image, feelings of personal insignificance and impotency, and a view of self as old. As time goes on, predictably residents within the control are likely to become more docile and submissive, show a low range of interest and activities and to live in the past rather than the future. They are likely to become severely withdrawn and unresponsive in relationship to others.

The deleterious effects of the institutional process that have been documented by the present and earlier studies highlight the pressing need for practitioners, planners, and administrators of services to the elderly, to re-examine a number of prevailing conceptions related to the delivery of these services. In South Africa, services today are primarily

custodial. Relatively few long-term care facilities have attempted to provide intellectual or sensory stimulation for their patients. Possibly, part of the reason is that the costs of running homes is now so high that additional staff is taken on only with great reluctance. Furthermore, because the responsiveness of many of the patients is so minimal, only the most persevering worker will continue to try to elicit meaningful interactions with her aged clients. Unfortunately, the more the staff members fail to interact with the residents, the more they do things for the residents instead of taking the extra time to help the residents do things for themselves, the more, in short, they give up on the residents, the more the residents sink into despondency and turn their thoughts and feelings inward.

Most staff members working within aged residential settings have had no training in the field before coming to the home, receive little or no in-service training, and are very poorly paid. Relatively few of them enjoy the tasks they are required to perform and many are not particularly attracted to working with people who are so demanding. Administrators are frequently so involved with the immediate and highly demanding problems of day-to-day functioning that they have little time to consider staff training and little energy to encourage the necessary programs and social interactions that might help their patients. Lacking cognitive or sensory stimulation, those patients who are already ill and confused become more so. Given these findings it is not surprising that professionals, para-professionals and administrators in the care of the aged are too often insensitive to their needs.

What are the needs of the elderly who are entering residential care? In reviewing the kinds of needs that older people bring to hospital or to residential care it is possible to look at general needs of older people as a group as well as the specific needs of individual

patients or residents. As a group, older people have a right to live satisfying lives, and in order to do that, they should be able to exercise choice within a flexible environment to achieve a balance between inner needs and external pressures. In addition to this, some other criteria of adequate adjustment can be suggested : it is important to be able to seek a continuity between past, present and future, and to be able to accept the inevitability and 'rightness' of death, Perhaps, most importantly, older people need financial and material security in order to be able to achieve emotional security. Individuals entering institutional care do so because they have come up against barriers to the normal aging processes which lead to satisfaction. The objectives of long term care should be aimed at the restoration of those processes and at facilitating the achievement of individual satisfactions.

Admission to any form of residential or institutional care implies that the individual has in some way broken out or broken down, in his previous life (Berry, 1972). Older people coming into hospital or residential care are coming from a situation of crisis or breakdown and experience a set of quantitative and qualitative losses. This is not to say that they have failed in their outside life: simply that they have come up against barriers that were insurmountable without help. Admission to care also implies a lack of suitable care in their own home.

The fundamental problem of any individual, at any age, admitted to any institution, is the conflict between the need to feel safe, secure and wanted and the need to remain an independent, integrated, whole person. In the old persons home, the residential worker should be concerned with maintaining a balance between these two needs. Unfortunately, in practice, this objective fails, Let us try to understand why.

As we have said elsewhere, most if not all the old people who come into care do so as a result of some crisis in their home. This may have been an environmental problem (poor housing, increasing brain failure leading to deteriorating standards, etc.), a relationship problem (insufficient supports, family stress) or a problem of physical illness or increasing disability. The elderly individual is therefore coming into a strange environment at a time of low personal strengths. It may well be that he has been battered into a state of apathetic withdrawal from the world and his first need is for the repair of the damage that has been done.

This is usually translated by the staff into a primary need for physical care and attention which includes warmth, food and comfortable surroundings. Nurses and nurse aides tend to be preoccupied with the physical care of elderly because they enjoy nursing, are trained to nurse, and are often unaware of people's emotional needs owing to one-sided physically biased instruction. Sometimes fear plays a part in creating an over protective atmosphere. Traditionally, hospital staff fear trouble and believe any involvement with the coroner means serious trouble. Because of this, as well as for nobler reasons, abnormal efforts may be made to prevent residents injuring themselves. If an elderly patient falls in a hospital and fractures a limb, he might die and this might result in an inquest. To prevent this rather uncommon chain of events, any patients who are restless or unstable on their feet may be confined to bed. If the patient continues to be restless, the bed may be converted into a cage by the use of cot sides, or made up on the floor of a side room. In summary we see the need to supply physical care is turned into overprotection.

Over-protection extends beyond care of the patient to the care of their possessions. Following admission to some hospitals, patients

are stripped of their personal property, including money, clothes, contents of pocket or handbags, dentures, spectacles and hearing aids. Many reasons for depriving patients of these articles are given by nurses, administrators, and doctors. Property may be lost or damaged and relatives will complain and public money will be wasted on replacement or repair. Dentures get muddled and patient may be given the wrong set, while hearing aids not only are liable to damage but require adjusting which takes up valuable nursing time.

When it comes to meal times - aides and nurses usually stand while they feed people who may be unable to feed themselves or may simply need more time than others are willing to let them have to feed themselves. There are two practices here that are destructive of dignity : the person who is being fed by someone who is standing cannot help but feel that he is imposing on the time of the feeder, that his eating is just a necessary function rather than a process of enjoyment. It is human beings that make of eating a satisfying social occasion; it is animals who take in food to survive. The old person who is deprived of the social aspects of mealtimes is made to feel that much less of a person.

In talking to the patients and about them, the attitude of aides and nurses is too often the attitude that adults reveal toward children : they patronise or scold. Symbolic of the adult-child relationship is the following form of address ...

"Eat up your breakfast Jenny, or you won't be able to go into the sun-room with the others."

"Don't you want to look nice when your daughter comes to see you? Let me tie your hair back so it looks nice."

The element of dependency fostered by these practices is apparent in the developing attitude of many old people toward themselves when they must rely on service of this kind. They begin to think of themselves as being troublesome and so many of them have a tendency to keep their concerns to themselves. Dependency gives the aged serious misgivings, fears and guilt feelings. Most aged persons react with guilt to the need to have others help with activities of daily living. Dependency involves a reversal of role by the aged person which to all intents and purposes is unnatural. An adult does not become a child even if his memory is impaired and his ability to concentrate is severely limited. Perceiving him as a child and treating him like one, and then justifying it in terms of a natural reversal of roles that comes with the old person's dependency is bizarre. Treating an old person like a child negates all he has learned, all he has been, all he has experienced- and, in the process, negates him as a person. To treat him as if he has forgotten many things is not the same as treating him as if he does not have anything to remember.

From the above discussion we can clearly see that the urgency to care for physical needs in the aged produces a multitude of negative effects which in the long run are more detrimental to the resident in question. The author would go so far as to say that this type of intervention contributes to the social breakdown syndrome, which suggests that an individual's sense of self, his ability to mediate between self and society, and his orientation to personal mastery are functions of the kinds of social labelling and valuing that he experiences in aging. That is the social conditions within the institution (role loss, vague or inappropriate normative information, and lack of reference groups) deprive the individual of feedback concerning who he is, what roles and

behaviour he can perform, and in general, what value he is to his social world. This feedback vacuum creates a vulnerability to and dependence on, external sources of self labelling, many of which communicate a stereotyped negative message of the elderly as useless and obsolete.

While it is true that eliminating the noxious conditions of existence will help create a benign environment, and while liberation from functional ethics will legitimise the creation of new options for action, the person must experience the source of his action, the locus of control, as resting with himself. To enable the development of an internal locus of control those who would envision themselves as serving the elderly must define as one of their major goals the systematic deinvestment of their power and control ...

They must at all the subtle junctures of decision making, policy formation, and administration, acknowledge the experiential value to their clients of individual power and control. Self government, resident directorship, political advocacy, and aging group consciousness are all part of the beginning vocabulary of practitioners which underscores this view, i.e., self-determination and individual control of policy and administration is the foundation for competent aging.

(Kuypers and Bergston, 1973, p.188)

In the section that follows, the author will attempt to identify the emotional feelings that the new resident brings with him/her upon entering a residential setting. Despite coming in at a time when losses are so prevalent, there are hopeful expectations that repair can take place. It is as if someone, somewhere within the cornerstone of the institution will 'give me all I ever longed for'. Basically, the

deal that the resident hopes for is that someone will take away all the pain. In other words, the newcomer appears to need someone on whom he/she can evacuate all the problems into. The new inmate is looking for someone temporarily to carry his/her anxieties, to share the burden and to help towards finding a solution. This therefore can become the basis of a realistic helpful relationship. The human's need to find someone who is a good listener, capable of carrying anxiety is a priority in the newcomer's list. Yet, as we have demonstrated, in most circumstances this is rarely met.

To be loved is every human being's most ardent desire. At the deepest level this means being loved as we are, with all our faults and shortcomings. This requires that someone should understand us in the widest sense of the term and yet not reject us. It is such understanding that the aged resident is striving for. Yet there is always the doubt whether it is possible to be loved if the truth were known.

The newcomer is not without fears. As the old person has entered the institution because there has been a failure in dealing with himself, his family or the outer world, the notion that he will be criticized is near at hand. He may be full of self-reproaches - 'it's all my fault' or adopt a belligerent attitude. Feelings of guilt may lead to the withholding of important information or blaming someone else. Guilt and a moralistic outlook lead to fear of punishment. Hence we see that the elderly person coming into a new environment is particularly vulnerable and has definite fears of being abandoned.

Therapeutically, the logical thing to do is to allow all these feelings to emerge. Before doing so, we must ask the question, what does facilitating expression of feelings actually mean for staff members? Essentially it pre-supposes that the people in caretaker roles can

resident their own anxiety levels escalate. There is an intense fear of doing harm. The worker/nurse may be afraid of what forces she is unleashing when she allows her client's feelings to emerge and is ultimately afraid of things getting out of control. The author postulates that in the majority of cases these people are afraid of their own reactions and find some emotions too painful and disturbing. As a defence against this, the helper in question resorts to two possible alternatives.

The first possibility is to hide behind the authoritarian structure which exists and is so powerful in institutional settings. This then allows one to become demanding and controlling of the resident's behaviour. Authoritarianism spreads down from the top to all grades of staff. A 'pecking order' evolves, with staff passing the blame for anything that goes amiss. Everyone with the slightest authority develops a domineering attitude, coupled with a fear of those above. Assistant nurses, afraid of the ward sister, shout and push patients who do not respond quickly to orders. When things go wrong every effort is made to cover up the truth, facts are distorted, frank lies become commonplace, and true communication between staff is almost non-existent. Residents are always seriously affected. Their freedom is liable to restriction, deviant behaviour is punished, ill-usage covered up, out-dated methods of treatment continued, and all the conditions productive of institutional neurosis fostered.

The second alternative is to become over-protective. Nurses are too often concerned solely with the observable physical needs of old people, and the tendency is to ignore everything else about them that goes to make up the human being. At least one study (Hefferin and Hunter, 1975) has indicated that, even when nurses had the psychological and social information about patients, based on nursing histories, most

of them did not use this information to improve patient care. In the final analysis, it is too threatening to take on the emotional pain of residents in question. It is far easier to treat newcomers as if they were, at best, children and, at worst, mindless. Nothing could be more indicative of the anti-humanistic stance of a profession committed to alleviate human suffering than the denial to old people of the dignity of their own persons.

The results of the Crisis Intervention group within the present study indicate that using this technique it is possible to contain the emotional pain of the resident. At the same time certain techniques provide the person in question with the resources to deal adequately with the pressures of the environment in an ongoing sense. In all cases treated with this approach, the therapist attempted to get the resident to clearly 'spell-out' his/her needs and then looked at specific methods to meet them within the constraints of the residential setting. What follows here is a brief consideration of some but by no means all of the more common intervention tactics employed by the crisis therapist.

(1) Listening : Despite the high premium that is placed upon therapist activity and aggressiveness great value was attached to listening. At all times the therapist was attentive to the client's need for expression and catharsis, allowing him adequate leeway to verbalise his emotional reactions, intellectual understanding of the problems, and ideas regarding their solution. An emotional climate which could contain expression of anger, helplessness, guilt and depression was cultivated.

(2) Utilizing interpersonal resources : It was found that rarely did the resident experience problems alone. Almost invariably, others close to the relative were affected, if not directly involved. Indeed, more often than not, it was found that the onset of problem often resulted

from interpersonal difficulties. This being so, the crisis therapist encouraged involvement of significant others on the client's behalf and in addition, encouraged the client to seek personally and utilize the help of others. Where appropriate and feasible, certain of the clients closest friends and/or family members were included in the treatment process.

(3) Utilizing institutional resources : A lot of time was spent explaining and giving advice as to how the system operated and what consequences certain behaviours would result in. That is to say, the resident was given advice and direction in how to gain maximum benefits from the environment as well as to ward off unnecessary hostilities.

(4) Advocacy : Related to the utilization of interpersonal and institutional resources is client advocacy. Many client problems were directly related to the failure of certain individuals or institutions to respond appropriately to their legitimate needs. To avoid fostering dependency, the crisis therapist encouraged such clients to turn to alternative resources or to develop more effective ways of approaching the unresponsive parties.

(5) Advice and suggestion : Though frowned upon by many traditional psychotherapists, advice and suggestions were given in appropriate circumstances. This was followed up with assignment of behaviour tasks, often designated as "homework" for the client to practice particular coping skills that may ^{ultimately} help in the resolution of problems.

Using these and other crisis intervention strategies (see Appendix 6) it appears that we have curtailed the emotional, cognitive and social disequilibrium associated with the admission to an aged home. At

the beginning of the third month of residency, members within the C.I. group seem to get many of their needs met. Many of the long-term negative effects of institutionalization have been staved off using crisis intervention techniques. It would therefore appear that these approaches should be made available to practitioners, planners and administrators of homes who deal with the aged. The advantages of these techniques are :

- (1) Crisis Intervention is readily available and brief.
- (2) Crisis Intervention deals not simply with individual clients but with families and social networks.
- (3) Crisis Intervention addresses itself to no singular definition of crisis but rather to a wide range of human problems.
- (4) Crisis Intervention is focused upon the client's present problems.
- (5) Crisis Intervention seeks not only to resolve the presenting problem of "crisis" and to relieve symptoms, but also to help clients develop more adaptive mechanisms for coping with future problems and crises.
- (6) Crisis Intervention is reality oriented.
- (7) Crisis Intervention requires therapists to take non-traditional roles in dealing with their clients.

The above skills should be made available to personnel working in the field of residential care for the aged so as to equip them to deal effectively with the difficulties that their residents undergo in the struggle to become well-adjusted.

So far, the discussion has been focused on the needs of the elderly resident but resident workers, too, have needs of their own : they are also involved in a large number of practical tasks in the provision of care, which should be considered.

The administration of practical provisions is a very large part of the residential worker's task and the amount of support that he receives in carrying out this function will determine the amount of time that he has available for tasks such as promoting group interaction and planning for individual needs. This support will take two principal forms : the actual number of staff available to provide care for the resident group, and the nature of staff supervision and development, and management back-up facilities.

It is difficult to draw any conclusions about the need for change in staffing ratios. The needs of residents in all forms of institutional care vary considerably from the relatively fit and ambulant to the bedfast and demented. Staffing policies have to account for these variations in planning for development. In this particular area of planning and development, research into appropriate staffing levels is clearly needed.

The second major area of staff support is that of supervision and management back-up. This is an area which is severely lacking in the South African context and a great deal of effort, time and money needs to be ploughed into this area. Dealing with infirm, confused, sometimes aggressive and hostile, and frequently dependent old people is very demanding. In order to be able to separate themselves from the needs of residents and to make more objective assessments, workers need to be able to examine themselves and their reactions in discussion with colleagues - not necessarily administrative superiors. Staff groups, therefore, need to be created where all people involved in the care of the elderly can get together to share and discuss their perceptions and current feelings towards particular residents. Nurses, doctors, occupational therapists, social workers, and residential workers rely heavily on

domestic staff, catering staff and other auxillary groups. All these workers are in face-to-face contact with patients and residents; sometimes the cleaner is likely to see as much of the old person as the residential worker. It is important that the general objectives and aims of the workers can be shared and discussed, even though information about individual resident's needs is not shared in detail. The therapeutic environment and the general living environment are bound to work more effectively if the general aims of all the workers who are involved are held in common. This approach, which ultimately gives workers a sense of being self-contained is so necessary if they are to be effective in dealing with behaviour.

Firstly, we have seen that unless some type of active intervention is undertaken within residential settings for the aged, and secondly, that unless extensive promotion of staff training is carried out via supervision, the picture remains pessimistic. In summary, this study has highlighted the fact that Crisis Intervention as a therapeutic strategy can have far-reaching effects in the promotion of adjustment of elderly individuals to aged homes. The above, however, is just a beginning and it is hoped that confirmatory research and the development of new programs will ensue. Successful care, in any situation, for the older person in need will involve a recognition that solutions should aim to deal not just with the limited view of the here and now, but should be concerned with the restoration of an aging process, with the satisfactions that this will imply. The individual aging process can continue with satisfactions and contentment in residential care if workers recognise the need to seek a pattern of successful aging for each individual in a flexible way.

9.1 Implications for Theory :

The author would like to suggest that the nature of this research has significant theoretical implications for Life Span Developmental Psychology. The goal of life span developmental psychology may be defined as an attempt to understand human development from conception till death, or, more simply, an attempt to understand the processes that define normal aging. But life span developmental psychology is not entirely concerned with the age variable. In many cases, the age variable has become a meaningless variable. Chronological age is really of little interest to the developmental psychologist. What is of interest is the process by which an individual develops and changes over time i.e. ontogenetic development. Behaviours present in the adult will have their roots in behaviours present and learned in the child, and that child will learn behaviours as a function to a large degree of the behaviours that the adults around him have learned.

This issue around which much discussion has been generated, is that of Attachment : Conventional definitions of attachment are usually restricted to the establishment of social bonds. Although attachment theorists often state that many persons can be the objects of an attachment relationship for any given individual, the overwhelming emphasis of both theory and research has been on the mother-infant dyad.

The child has a number of physiological needs which must be met, particularly for food and warmth. In so far as a baby becomes interested in and attached to a human figure, especially mother, this is the result of the mother's meeting the baby's physiological needs and the baby's learning in due course that she is the source of his gratification. There is in infants an inbuilt propensity to relate themselves to a human

breast, to suck it and to possess it orally. In due course the infant learns that, attached to the breast, there is a mother and so relates to her. There is in infants, an inbuilt propensity to be in touch with and to cling to a human being. In this sense, there is a 'need' for an object independent of food which is as primary as the 'need' for food and warmth (Bowlby, 1971).

It is through the attachment process that one gains a sense of mastery, control or power. Initially, the young infant is weak, powerless, and vulnerable. He has relatively little control over his own self and even less over people and things in his environment. By initiating action the infant tries to control his/her own body processes. Brazelton's work (1961) corroborates this statement. By exhibiting their pleasure with smiles and similar behaviour, neonates can achieve some modicum of control over others and therefore, over the social environment. The feedback that the infant receives reduces feelings of vulnerability and helplessness and, in a sense, provides a basis for generativity and further risk taking.

With increasing age, the child gains more sophisticated skills which are then used to meet the emotional and social needs necessary for development. The child is permitted increasing power and mastery based on his own competence, without risking loss of the attachment objects. It is the notion of self-produced feedback (Kalish and Knudson, 1976) that actually aids us in understanding how healthy development of interpersonal relationships occurs from infancy to adolescence and later into the emerging adult.

In old age, a lot of these processes become reversed. In many ways, mastery and control begin to diminish, while vulnerability increases :

Physical strength and endurance are less; psychomotor and sensory capabilities may be less effective than in earlier years; health problems increase; sometimes memory and other cognitive processes are affected; finances are reduced; the status, power and influence that have previously been available through the roles of parent, workers, and community member are also likely to diminish

(ibid p.174)

To all intents and purposes there is a reduced ability to control the environment and thus to be able to provide oneself with the important social others with whom the attachment relationships have been established. Instead of maintaining the power in the attachment relationships, elderly people undergo a process of increasingly egalitarian relationships with their own children. With the onset of very old age and illness the power balance alters again, with the old person finding his control of the situations severely limited. Old people need their children to provide them with affection, help them financially, transport them, explain the changing world and so on.

Vulnerability increases rapidly and for many, the dreaded alternative of institutionalization looms on the fringes of consciousness. Research indicates that more than any other single factor, having a confidant in whom attachment seems ongoing, appeared to discriminate between elderly persons who were institutionalized and those who could remain in the community (Lowenthal and Haven, 1968).

Theorists (Cumming and Henry, 1961) have seen entrance into institutions as an expression of detachment most often associated with an affective withdrawal. It is their belief that this process is irreversible, and in many instances, desirable. The essence of the present research, however, has taken a stand which is diametrically opposed to that of

these authors. Detachment is viewed not as a dimensional opposite of attachment which is terminal, but rather as temporary and reversible. The author has attempted to create a situation which allows for the development of a meaningful relationship for aged institutional newcomers, at a time when their affective and interpersonal resources are depleted. In both treatment groups the worker's objective was to enhance the resident's ability to control or master the environment. Results indicate success in the treatment group undergoing crisis therapy. Presumably this reflects the fact that a significant relationship has been re-created in which the resident gains the feedback that he or she requires. It appears the the therapist has helped the elderly to produce self-initiated behaviour which has induced social feedback.

It thus appears that one important life-span dynamic in the area of attachment may be conceptualised in terms of self-produced feedback or power in the broadest sense. Classically and non-pejoratively, the root derivations of the word power come from words meaning to be able to, to be possible, to act effectively. Perhaps our competence and our self-concept interpersonally and inter-environmentally is centrally related not only in infancy but throughout life to the process of self-initiation and attendant feedback. The necessity to view the concept of attachment throughout life span development has become painstakingly clear. A life-span developmental perspective can provide an integrative context for evaluation and treatment of the elderly. Institutions need no longer be viewed as the environment designed to contain degeneracy but rather as places where the opportunity to develop significant re-attachments occur, at a time when so many of their residents are in a state of severe crisis.

In summary we see that metatheories of development and aging (as described in this section) set not only guidelines but also constraints.

Such metatheoretical constraints and guidelines involve statements about the potential range of modifiability, goals or optimization targets of intervention efforts, the scope of intervention transfer effects, strategies for the design of intervention programs, and the relative desirability of the intent to intervene. The strength of a developmental approach to intervention lies in comprehensive knowledge about the course and mechanisms of the developmental behaviour change process. Developmental knowledge permits a preventative design for optimization at all periods of the life span. A match between theory of development and intervention is always a desirable goal.

9.2 Implications for Future Research

It is only through research that the growth of knowledge increases. In the last fifteen years, there has been a quantitative explosion in the field of gerontology, so much so that at present a great deal of aimless and therefore meaningless investigation is being perpetrated. The U.S.A. is largely responsible for this output. "Publish or Perish" appears to be the order of the day (Birren, 1977).

If we are to give meaning to this "sea of figures", future research must attempt to study the aging process in the context of the real life situation. South Africa, an emerging third world country will in future have to deal with a much bigger "old age problem" as its community of senior citizens increases. The present study, designed to minimise certain problems can be regarded as pioneering. The relatively small sample size does not allow one to fully generalise the findings to the entire population of aged residents living within the confines of the institutional milieu. Before we can regard any of the results as being definite, confirmatory studies and future research programs are

necessary to substantiate present findings.

It would appear from this study that Crisis Intervention has been successful in aiding adjustment up until the third month of residency. However, this is a relatively short time span and further studies need to be carried out to determine the outcome of therapeutic intervention after one year. Clearly, at present, there is no conclusive evidence regarding the efficacy or utility of crisis intervention as a form of psychotherapy for aged subjects. So far there have been only relatively few serious efforts to evaluate this modality, and most of these have been so thoroughly plagued with problems of control and other methodological difficulties as to preclude any unequivocal interpretation of their findings.

The present study attempted to control for as many methodological inconsistencies as was possible and in so doing we had to make the follow-up assessment fairly soon after the cessation of treatment. Ideally the time gap should be been longer. Perhaps the value of this study as well as the present state of crisis intervention research can be best summarised by quoting Jerome Frank (1962). "What is most needed in research on psychotherapy", he has written ..

is originality of thought and courage to grapple with important issues, setting up as much control as feasible. Each experiment should lead to another which is an improvement over its predecessor. In this sense, a bad experiment is better than none, and several are better than one. Unless one makes the original crude experiments, no progress is possible. (p.25).

Despite the pessimistic findings with respect to the social attachment and activity program employed, more research studies in using volunteers from the community to aid the institutional elderly are necessary.

With respect to data gathering more research as to the reliability and validity of instruments used is necessary. Good assessment cannot occur without checks on the validity of specific test measures for criteria of relevance for older adults. Systematic standardization of geriatric tests on the South African population is also strongly indicated. Little or no work in this area has yet been carried out, and as such, our analyses are not entirely valid or reliable. Several additional directions seem fruitful for the future development of assessment techniques. We must begin not only to describe the present status of functioning, but also to determine possible and/or optimal levels. Most current tests do only the first alternative.

Judging from the current state of the clinical field outside gerontology the standard psychometric battery has declined in its centrality to the role of the clinician. In gerontological psychology, this is not necessarily a bad thing, if we could develop in its place a truly ecological approach to assessment. That is, the assessment task is to determine what an older person can do, given a particular situation or choice of situations. Thus, in rehabilitation, milieu therapy, or screening and placement, the clinician should be asked to choose dimensions of functioning, and tasks with which to measure them, that are relevant to the older person's environment. There is a great need to develop a technology of choosing relevant areas to test, finding the right testing techniques, and helping the older person and those who are in a position to help him to plan and function in an environment most congruent with his capacities (Lawton, 1970a).

In summary, pursuit of research on aging has three values; cultural, scientific and practical. A culture which does not encourage speculation or research on perhaps mankind's greatest dilemma, his aging and mortality,

would seem to be sterile. However difficult, acquisitions of generalisations about aging will be when we gain them, they are likely to be some of the most profound that mankind could possess.

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Appendices.

Appendix 1

The following is a description of the type of environment found in each home :

(1) Home A

This is a new home which opened last year. There are 83 residents, both male and female. Architecturally, this is an extremely modern and comfortable home, all rooms being private, tastefully furnished and having their own kitchenette and telephones.

This home is situated in an upwardly mobile residential area with maximum accessibility to both library and shopping facilities. It falls into the economic category and the cheapest tariff is R200 per month, placing it in the range of wealthy citizens.

The criteria for admission other than financial are :

- (1) that the new resident be independent, intelligent and motivated to create their own activity.
- (2) that he/she be able to take care of him/herself as this home only offers minimal assistance in regard to health and nursing services.

There is a small sick bay with one nursing sister in attendance. All residents have their own private doctors, visit district surgeons or attend out-patient clinics at the various hospitals. A social worker is available once a week to discuss problems that arise. The home has its own bus, and outings are organized at least once a week. Library services exist within the home. No occupational or therapeutic services are offered.

(2) Home B

This home was originally a hostel for girls, however in 1957 it

was converted into an aged home as there were no existing facilities or institutions prepared to accommodate individuals over the age of seventy years. The home has facilities for 185 residents, both males and females of various religious denominations being accepted. There are single and double rooms and facilities for couples are also available.

The home is situated in a predominantly lower-middle-class suburb. Although on the main bus-route, it is relatively isolated from shopping and recreational facilities. The home falls into the sub-economic category.

The criteria for admission are :

- (1) newcomers must be South African citizens.
- (2) they are usually in receipt of an Old Age Pension, and their gross monthly income totals less than R130 per month.
- (3) this home caters for the more senior aged resident and individuals from 70 years and onwards are considered eligible for admission.
- (4) newcomers must be ambulatory and in reasonable health.

Facilities offered by the home consist of a sick bay staffed by both trained nursing staff as well as nurse aids. Residents are able to remain in the sick bay until they become extremely frail or mentally disabled, whereupon they are referred to an old aged nursing home for chronically disabled individuals.

Services offered to residents include - occupational therapy; physiotherapy; a chiropodist and hairdresser visit the home once a week, as does a district surgeon and social worker. Church meetings are held regularly for the various different religious groups. The mobile post office and provincial library supply services to the home. Outings are arranged periodically.

(3) Home C

This is a well-established non-demoninational home catering for aged females. Each resident has their own private room. The home is situated in an upwardly mobile area, close to transport and shopping facilities. It is run by a utility company and relies on donations, bequests, and the tariff paid by the residents to maintain the upkeep of the home. This home falls into the sub-economic category.

Criteria for admission include :

- (1) residents must be female.
- (2) only individuals between 60 and 70 years are eligible.
- (3) newcomers must be ambulatory and in good health.
- (4) residents must be independent and able to take care of themselves as the home offers minimal nursing facilities.
- (5) residents are usually in receipt of an Old Age Pension or equivalent.

There is a small sick bay, however should a resident become extremely frail or mentally disturbed, they are referred to an old age nursing home for the chronically disabled aged. A social worker is available twice a week to deal with problems which may arise and a district surgeon visits the home periodically.

Residents are allocated into sewing and knitting groups where projects for the annual fete are organized. Library facilities are also available. Religious ministers visit the home and volunteers organize groups of outings to entertain the residents.

(4) Home D

This is a private home which opened a year ago. It was previously a hotel which has been converted into a home for the care of the aged.

The home offeres accommodation for 70 individuals in both single or double rooms which are comfortable and adequately furnished. It is situated close to library, recreational and shopping facilities. Both males and females as well as couples are eligible, irrespective of religious denomination.

The minimum tariff is R150 per month and upwards, depending on the type of room and medical attention the resident requires.

The only criteria for admission is that the resident must be in a financial position to afford the tariff.

Trained nursing staff are available on a 24 hour basis, since some of the aged at this home are in need of medical care. Residents have their own private doctors, visit district surgeons or attend out-patient clinics at the various hospitals. No social welfare services exist at this home and there is no occupational or physiotherapy offered. A service centre is in the process of being established with its aim being to motivate the residents to participate in creative activity.

(5) Home E

This home was started on the 1st. of July, 1971. There are 239 residents, both male and female of various religious denominations. The home is modern, luxurious and centrally situated. It falls into the Economic category, the cheapest single accommodation being R96 per month.

The criteria for admission other than financial are :

- (1) that the new resident be independent, and motivated to create their own activity.
- (2) that he/she be able to care for him/herself (as there are no nursing or medical facilities available).

Residents are required to provide for their own breakfasts and the

home caters for their lunches and dinners. Unlike most homes who offer laundry services, residents are required to do this themselves. Residents have their own private doctors, visit district surgeons or attend out-patient clinics at the various hospitals. There is no occupational or physiotherapy offered. The home has a social worker who is in attendance every morning. One of the outstanding features offered in the home is its service centre. Sewing and knitting groups, card games and library facilities are provided as well as entertainment. This offers residents the opportunity of socializing and maintaining as well as developing new relationships. The service centre is available to residents as well as to aged individuals from other homes and the community at large.

(6) Home F

This is the largest aged home in Cape Town and caters for between 265-275 aged Jewish males, females and in certain circumstances, couples. Architecturally, the home is large and spread out and residents are divided in the home according to their physical and mental state. The most independent residents are located on the lower ground floor. The ground floor contains the residents who display features of moderate impairment and the first floor contains the most severe physically disabled. This home has a separate wing for senile patients who are totally incapable of caring for themselves.

The home is extremely cut-off from shopping facilities and transport, thus isolating residents from mainstream community living. The home caters for lower, middle and upper class residents. The tariff is R250 per month minimum, rising to a maximum of R350 per month for the very frail aged. Where individuals cannot afford the tariff, their entire

old-age pension goes to meet expenses incurred by the home.

The only admission requirement is that residents be of the Jewish faith (however, in certain circumstances exceptions are made).

There is a sick bay with a matron and nursing sisters in attendance. Residents have private doctors, visit district surgeons or attend the out-patient clinics at the various hospitals. The home has two social workers, one full-time and one part-time. There is a full-time occupational therapist as well as a full-time physiotherapist. Hair-dressing facilities are also available. There is a synagogue, a library, and volunteers visit and arrange outings.

(7) Home G

This home is over a hundred years old and accommodates 72 Christian ladies. It is situated in Cape Town, in close proximity of the city centre. Because it is in a fairly dangerous locality, security measures are employed.

This home falls into the sub-economic category.

Admission criteria include :

- (1) residents are usually in receipt of a pension, and their gross monthly income must total less than R200 per month.
- (2) this home is exclusively for Christian ladies.
- (3) residents are required to be ambulatory, independent and in reasonable health.

There is a small sick bay with a trained sister and nurse aids in attendance. Residents visit private doctors, district surgeons, or attend out-patient clinics. Should residents deteriorate mentally and become uncontrollable, they are referred to an old age nursing home. There is no physiotherapy or occupational therapy. Library facilities as well

as religious facilities exist, and where possible outings are arranged. Some residents from this home attend a service centre which is in close proximity.

(8) Home H

This is a new home which opened on the 1st. February, 1979. It was previously a hotel and has been renovated to meet the needs of the residents. It is situated one street away from the beach in a middle-class area and residents have access to both library, recreational and shopping facilities.

The home has accommodation for 99 residents, both male and female irrespective of religious denomination.

The tariff is R85 per month minimum, rising to R150 per month.

The criteria for admission are :

- (1) residents must be ambulatory and in reasonable physical and mental health, since no specific health services are offered.
- (2) residents must be in a position to afford the tariff, however, when this is not possible, the home utilizes the resident's old age pension to meet necessary expenses.

There is no sick bay and residents visit their own private doctors, the district surgeon or attend the out-patient clinics of various hospitals. Should they become uncontrollable or extremely physically ill, they are referred to an old age nursing home. At present there is no physiotherapy or occupational therapy offered, however, intentions to start a service centre are in progress.

(9) Home I

This home was started in 1904 to serve the needs of the destitute aged

and orphaned children. Both groups are run by the same administrative body, however, they are housed in different units. The home has accommodation for 104 residents, both male and female, and although it is to a large extent financed and run by the Roman Catholic Church, they nevertheless accept all religious denominations.

The home is situated in a middle-class area and although there are large grounds within the home, residents are fairly isolated from shopping and recreational facilities. The home caters for individuals from a heterogenous population.

The criteria for admission are :

- (1) residents must be in need of both accommodation and care.
- (2) mentally and physically healthy individuals are preferred, however those who are frail are not excluded.
- (3) pensioners are preferred, however, individuals who cannot meet the financial requirements are not excluded from admission.

Facilities offered by the home include a sick bay with trained nursing sisters - residents are able to remain in the home until death. Services offered to residents include occupational therapy, physiotherapy, religious instruction and library facilities. Volunteers visit and arrange outings.

MODEL FOR TREATMENT IN CRISIS SITUATIONS

I. BEGINNING PHASE: FORMULATION (USUALLY COMPLETED IN FIRST INTERVIEW)

<u>Worker's Activity</u>	<u>Guidelines</u>
<p>A. <u>Immediate Focus on Crisis Situation</u></p>	
<p>1. Start with the "here and now". Focus on the <u>precipitating factor</u> the incident or event that prompted the client's referral or appearance: scope, persons involved, outcome, severity of effect, time event occurred.</p> <p>"What happened, what brings you in here now?"</p>	<p>By making the client focus on what happened in the recent past, try to help him gain cognitive awareness of the immediate situation through verbalization and ordering of all the aspects, including bringing into full consciousness those elements which may have been repressed or denied. Try to get as many facts as possible; make him tell you rather than rely on others who accompany and may be trying to shield him. Exact accuracy is not needed at this stage; the telling is the important feature.</p>
<p>2. Elicit subjective reactions to the event; try to get his affective responses to what happened and to the part he and others played in it.</p>	<p>The client may engage in a good deal of ventilation with crying, anger, blaming, expressions of guilt feelings. It is important to listen attentively and quietly but to pay close attention to any discrepancies, particularly between <u>what is being said</u> and <u>how it is being told</u>. Note the appropriateness of affect, amount of anxiety, degree of tension, and lability of emotions. The aim here is to free and bring out reactions to the current situation.</p>
<p>3. As the emotional pitch is lowered, try to place the client within the context of the crisis situation: find out the original <u>hazardous event</u>, and subsequent <u>blows</u> that started off and aggravated change. If unable to pinpoint, at least try to find out when things began to go wrong.</p>	<p>Here we get a weaving back and forth between the objective and subjective aspects of the situation. Be aware of recent losses, threats, challenges even if not consciously tied to the present situation. Look for connecting themes, repetitive patterns, actual or symbolic links to earlier crises and conflictual events. Do not attempt interpretations or confrontations at this point. Also avoid getting caught up in chronic pathology or in long-standing situational problems.</p>

4. Ascertain the nature and duration of the vulnerable state including changes in ability to manage, earlier attempts to cope with problems raised by initial and subsequent events, and previous efforts to obtain help.

Try to build up an orderly sequence of events. Keep the client focused on "So what happened then?" Try to bring out what worked and what didn't and other persons influencing the situation. Be alert to contributing factors behind differences between the client's responses and those of others involved.

Begin to build up your diagnostic assessment of what is going on: client's anxiety and discomfort levels; extent of guilt, fear, anger, depression, despair, hope; his appropriateness of affect and realistic appraisal of elements in the situation; his motivation to invest himself in change; his capacities in the thinking, feeling, behavioral, and physiological areas; his ability to function at an acceptable level and to engage in a working relationship; his defense structure and previous problem-solving patterns.

5. Assess the present situation, the state of active crisis: is he completely disequibrated or is the area of dysfunction limited to specific areas? Has the situation stabilized, or are changes still taking place?

For a horizontal scan of the client's current functioning in vital role networks, the extent to which his coping mechanisms are operating adaptively, the support systems and resources which can be called upon.

Formulate within your own mind the dynamics of the situation and decide whether to use the crisis approach or to try another form of intervention.

B. Evaluation of Current Predicament

1. Make a "decision statement" as to what you think is currently going on and what you see as the most pressing problem and the area on which to concentrate.

Here an attempt is made to partialize the "tangled ball" of problems and complexities and to decide at which level you are going to direct your intervention: generic or individual, material-arrangemental or psychosocial, etc.

Sometimes the problem as you see it can be phrased in terms of the "core dilemma" or quandary with which you see the client is struggling.

2. Ask the client how he sees the situation and what he regards as the most pressing problem, or the one he wants to work on first.

3. Together with the client, settle on one target problem upon which to focus. Occasionally, two allied problems can be worked on simultaneously.

At this point, the client may be too emotionally drained or in shock to respond actively with a problem-for-work. In this case you may have to take the initiative, postpone active intervention, or else work out plans with some significant other in picture. On the other hand, this "cutting the problem down to size" may give him hope and strength to bounce back with very definite view on what he wants to do.

C. Development of Contract for Further Activity

1. Work out a tentative agreement on joint activity: specific goals at which to aim, tasks on which to focus. Set up a working plan of what the client will do, what you will do, and what others involved will contribute. Be as specific and concrete as possible.

Coming to an explicit agreement on mutual goals and expectations is an integral part of the crisis approach, whether expressly put in terms of a contractual arrangement or not. Its main purpose is to treat the client as a mature, functioning adult who is expected to carry out his part in the agreement. This is definitely an ego-syntonic approach that evokes a positive response.

II MIDDLE PHASE: IMPLEMENTATION (FROM FIRST TO FOURTH INTERVIEW)

A. Organizing and Working over Data

1. Obtain missing background and face sheet data, particularly around the current life situation and recent past since the hazardous event. Try to get a clearer, more coherent picture of what has been going on and is still happening.

This is aiming at further cognitive awareness, started in I-A1. Now, however, the tone is different. Once the decision to become involved has been made and the promise of help given, the client's reaction and level of participation often change dramatically. He begins to talk more rationally and connectedly; he becomes more informative and less guarded, more willing to cooperate actively so that greater detail and accuracy can now be achieved.

2. Select from what you have heard several central themes which have come out, e.g. losses or assaults to self-esteem. Ask about them, both in the present and -if appropriate or the client has brought it up - in the past.

Be particularly aware of gaps and discrepancies and either bring them up or file them away for future reference.

This can be the heart of the intervention. As you "hit a nerve", you often get a flood of emotions, with all sorts of ties and associations. Much of the material brought out in I-A3 comes up again. This time, however, do go into it, offer interpretations, bring up connections and recurring motifs.

If the client's affect is appropriate, you can share his indignation and anger or empathize with his grief and sorrow. If the feeling is appropriate but the object is not, point that out and help channel anger or guilt into more reality-oriented directions. If the feeling is appropriate, but the client's time sense is wrong, be the "voice of reality" and point out the discrepancy and try to get an unlinking. And if the feeling is not appropriate, that too should be questioned.

Keep interpretations relatively close to the surface and emphasize reality factors and ego functioning. Sometimes the focus can be put on role change and the difference between "what is" and "what ought to be", on role discrepancies and differences in role expectations.

B. Bringing about Behaviour Change

1. Go back to I-C1, to the area for action agreed upon. Identify how the client has coped with the situation in the past, what was the outcome, how effective or ineffective it was in dealing with the crisis situation and restoring balance.

This is your primary area of intervention during this period: helping the client identify what worked, didn't work; what are his alternative ways of action; what are the resources, in himself, out in the community, and in his life networks, which can be utilized in his learning to cope effectively; and how to get him started in making changes.

2. Set up some overall task areas or intermediate goals which can be aimed at and realistically achieved in a short period of time.

3. Work out a series of specific tasks together, designed to help client reach the goals set. These tasks can be action oriented and geared to bring about change in performance.

4. Tasks can also be thinking oriented, to help the client decide on a course of action or ways to implement it.

The client's high anxiety and discomfort may become vital forces here in speeding up the tempo of action. However, anxiety can reach the point where it may become paralyzing.

It should be kept in mind that the client is the primary executor of tasks to be set. If you participate, your purpose is to act on his behalf or jointly with him until he is able to carry on alone.

Giving the client "homework assignments" is a useful device to get him started; it also gives you a good starting point at which to open the next interview.

Interspaced between task arrangements, give the client support and encouragement, particularly around a new activity in which he has not engaged in before or one that recalls old memories and unhappy associations. If obstacles arise or if he becomes upset or discouraged, discuss alternate ways to carry out tasks and arrive at goals.

Act as a role model to indicate positive ways of handling the problem situation.

A difficult problem for practitioners during this phase of crisis treatment is what to do when clients begin to regain their independence of action. While we see this as the end goal, it often results in a rapid change in plans and a shift in direction that make it hard for the worker to "keep on top" of what is going on. It involves a shift in worker role from engaging in a good deal of direction and activity at the start of the case to becoming more passive and retiring to the

sidelines at the client regains his autonomy and fills up his lifespace with new relationships.

III ENDING PHASE: TERMINATION (LAST ONE OR TWO INTERVIEWS).

A. Arriving at the Decision to Terminate

1. Keep track of passage of time; remind the client how much time or how many interviews are left, according to the original agreement.

The time factor assumes particular importance in the last phase of treatment. Since crisis situations are often transitory and provide their own solutions, termination in some cases is predetermined,

If tasks have been carried out successfully, the client may begin to feel restless and want to be on his own by now. Frequently a client will call after several sessions to say, "I've been thinking about what you said and I've decided to ... "

2. If no overt agreement was made, suggest a spacing out of contacts, with a view toward termination

3. Deal with resistance to terminate, on both your and the client's part.

In intensive crisis treatment, three kinds of termination reactions can be found: clients who realistically wish to terminate upon completion of the contract; those who request ongoing therapy as a defense against termination; and those for whom ongoing treatment is both wanted and appropriate. These must be dealt with individually in each situation; if the worker is uncertain or feels too involved, it helps to consult with other professionals at this point. A key factor is the client's current level of functioning.

B. Reviewing Progress in Case

1. In the last or next-to-last interview, suggest summarizing the progress in the case since the start of intervention.

While evaluation of progress is an important aspect in any case, in crisis situations it becomes an integral part which serves to tie together loose ends and makes the treatment experience a positive one, stressing and building of feelings of efficacy and competence.

2. Review progress in terms of key themes, basic affective issues.

Because clients come in originally at moments of high tension and upset, they are often unable, or too embarrassed, to recall now how things were then. The emphasis here should be on recognizing the difficulty imposed by the initial event, the extent of the client's early disequilibrium, and the rapidity of his reintegration - the distance travelled.

3. Go over tasks covered, goals reached, changes in direction taken, and work not completed.

This can be a very moving mutual experience and requires a good deal of skill to handle the transference elements in the situation, ranging from excessive gratitude to anger at being deserted. A frequent reaction is "You didn't do anything for me; I would have gotten over it by myself!"

C. Planning Future Activity

1. Discuss current status and what are the client's plans for the future, when he will be on his own.

Here the emotional tone is lowered and you resort to working out practical, reality-oriented details and specific arrangements regarding persons to contact in the community and what the client can expect to happen. Writing down names, addresses, and directions is helpful for anxious clients who are apprehensive of going out on their own.

Worker's Activity

Guidelines

2. Close the door, but leave a crack open; set the tone for the client's feeling that treatment in the crisis situation was a complete experience in itself.

This is a very delicate line that in crisis treatment requires skill in handling; on the one hand, you want to emphasize the client's independence; on the other, you want him to feel free to return in case of need.

In the event that further treatment on a more extended basis is planned, it may be advisable that it not be with the same worker or at least that a time gap be inserted so that it becomes a "different ball game".

(Golan, 1978, p.84-94)

APPENDIX 3

Interests and pleasures (describe)

Avocations or hobbies : _____

Sports : _____

Commercial recreation (movies, nightclubs, etc.) : _____

Music : _____

Languages : _____

Travel (places and years) : _____

Vacation habits (what do you do and how often?) : _____

Gardening : _____

Collect anything : _____

Pet(s) : _____

Use of community centers, senior centers, etc. : _____

What is the most characteristic thing you do to relax and unwind? _____

How many hours a day do you watch T.V.? _____

How many hours a day do you engage in your other interests and pleasures
(excluding T.V.)? _____

Are you satisfied with the balance between work and play in your life?

APPENDIX 4 A

THE LEFEVRE MORBIDITY SCALE (1977)

<u>PAIN</u>	0	None)	
	1	Mild)	Clinical assessment based on observation
	2	Moderate)	and self report.
	3	Severe)	
<u>DYSPNOEA</u>	0	None - very slight	
	1	Slight shortness of breath on exertion - can do housework.	
	2	Unable to do housework.	
	3	Bedfast.	
<u>VISION</u>	0	Normal visual acuity - with or without glasses.	
	1	Needs very good light, large letters.	
	2	Distinguish fingers.	
	3	Dark light	
<u>HEARING</u>	0	Normal with or without hearing aid.	
	1	Raised voice needed with or without hearing aid.	
	2	Loud shouting needed with or without hearing aid.	
	3	Totally deaf.	
<u>STIFFNESS/ WEAKNESS</u>	0	None - very little.	
	1	Able to do most activities.	
	2	Needs constant help with activities because of stiffness/ weakness.	
	3	Totally incapacitated because of stiffness/weakness.	
<u>INCONTINENCE</u>	0	Nil	
	1	Very occasionally urine/faeces	
	2	Almost always urine/faeces.	
	3	Never, or virtually never incontinent.	

CLINICAL ASSESSMENT OF PHYSICAL MORBIDITY AND SYSTEMS AFFECTED

PAIN	—
	—
DYSPNOEA	—
	—
VISION	—
	—
HEARING	—
	—
STIFFNESS/ WEAKNESS	—
	—
INCONTINENCE	—
	—

SYSTEMS INVOLVED

1. C.V.S.
2. R.S.
3. G.I.T.) Including liver, gall bladder and bile ducts,
4. G.U.S.) spleen, oesophagus.
5. C.N.S.
6. Musculoskeletal.
7. Metabolic/endocrine - vitamin and mineral deficiency.

APPENDIX 4 B

PHYSICAL SELF-MAINTENANCE SCALE

Subject's name

Rated by

Date

Circle one statement in each category A-F that applies to subject.

A. Toilet

1. Cares for self at toilet completely, no incontinence.
2. Needs to be reminded or needs help in cleaning self, or has rare (weekly at most) accidents.
3. Soiling or wetting while asleep more than once a week.
4. Soiling or wetting while awake more than once a week.
5. No control of bowels or bladder.

B. Feeding

1. Eats without assistance.
2. Eats with minor assistance at meal times and/or with special preparation of food, or help in cleaning up after meals.
3. Feeds self with moderate assistance and is untidy.
4. Requires extensive assistance for all meals.
5. Does not feed self at all and resists efforts of others to feed him.

C. Dressing

1. Dresses, undresses and selects clothes from own wardrobe.
2. Dresses and undresses self, with minor assistance.
3. Needs moderate assistance in dressing or selection of clothes.
4. Needs major assistance in dressing, but cooperates with efforts of others to help.
5. Completely unable to dress self and resists efforts of others to help.

D. Grooming (neatness, hair, nails, hands, face, clothing).

1. Always neatly dressed, well-groomed, without assistance.
2. Grooms self adequately with occasional minor assistance, e.g. shaving.
3. Needs moderate and regular assistance or supervision in grooming.
4. Needs total grooming care, but can remain well-groomed after help from others.
5. Actively negates all efforts of others to maintain grooming.

E. Physical Ambulation

1. Goes about grounds or city.
2. Ambulates within residence or about one block distant.
3. Ambulates with assistance of (check one) (a) another person ____
(b) railing ____ (c) cane ____ (d) walker ____ (e) Wheelchair ____
 1. ____ gets in and out without help.
 2. ____ needs help in getting in and out.
4. Sits unsupported in chair or wheelchair, but cannot propel self without help.
5. Bedridden more than half the time.

F. Bathing

1. Bathes self (tub, shower, sponge bath) without help.
2. Bathes self with help in getting in and out of tub.
3. Washes face and hands only, but cannot bathe rest of body.
4. Does not wash self but is cooperative with those who bathe him.
5. Does not try to wash self, and resists efforts to keep him clean.

APPENDIX 4 C

PAMIE SCALE

NAME : AGE : SEX :

MARITAL STATUS : FOLDER :

DATE OF ADMISSION :

..... AT BY
DATES OF AT BY
EVALUATION AT BY

P A M I E

(1) Factor SCD

1. NO
2. YES
3. NO
4. YES
5. NO
6. YES
7. YES
8. NO
9. NO
10. NO

SCT TOTAL

(2) Factor BELL

1. YES
2. YES
3. YES
4. YES
5. YES
6. YES
7. YES
8. YES
9. YES
10. YES
11. YES

BELL TOTAL

(3) Factor MENT

1. YES
2. YES
3. YES
4. YES
5. YES
6. YES
7. YES
8. YES
9. YES
10. YES
11. NO
12. YES

MENT

(4) Factor ANX

1. YES
2. YES
3. YES
4. YES
5. YES
6. YES
7. YES

ANX TOTAL

(5) Factor BED

1. YES
2. NO
3. a. (5) YES
b. (4) YES
c. (3) YES
d. (2) YES
e. (1) YES
4. YES
5. NO
6. YES
7. NO

BED TOTAL

(6) Factor DET

1. YES
2. YES
3. YES
4. NO
5. YES

DET TOTAL

(7) Factor SUSP

- 1. YES
- 2. YES
- 3. YES
- 4. YES
- 5. YES
- 6. YES

SUSP TOTAL

(8) Factor SENS

- 1. YES
- 2. YES
- 3. a. (1) YES
- b. (2) YES
- c. (3) YES
- 4. YES

SENS TOTAL

(9) Factor WAP

- 1. YES
- 2. YES
- 3. YES
- 4. NO
- 5. YES

WAP TOTAL

TOTALS

- 1. SCD
- 2. BELL
- 3. MENT

- 4. ANX
- 5. BED
- 6. DET

- 7. SUSP
- 8. SENS
- 9. WAP

APPENDIX 4 D

THE BRIEF PSYCHIATRIC RATING SCALE

Mark on right half of scoring sheet on row specified.

RATING SCALE

	0	1	2	3	4	5	6	7	
	Not assessed	Not Present	Very Mild	Mild	Moderate	Moderately severe	Severe	Extremely Severe	RATING
1. SOMATIC CONCERN	Degree of concern over present bodily health. Rate the degree to which physical health is perceived as a problem by the patient, whether complaints have a realistic basis or not.								
2. ANXIETY	Worry, fear, over-concern for present or future Rate solely on the basis of verbal report of patient's own subjective experiences. Do not infer anxiety from physical signs or from neurotic defense mechanisms.								
3. EMOTIONAL WITHDRAWAL	Deficiency in relating to the interviewer situation. Rate only the degree to which the patient gives the impression of failing to be in emotional contact with other people in the interview situation.								
4. CONCEPTUAL DISORGAN- ISATION	Degree to which the thought processes are con- fused, disconnected or disorganized. Rate on the basis of integration of the verbal products of the patient; do not rate on the basis of patient's subjective impression of his own level of functioning.								
5. GUILT FEELINGS	Over-concern or remorse for past behaviour. Rate on the basis of the patient's subjective experiences of guilt as evidenced by verbal report with appropriate affect; do not infer guilt feelings from depression, anxiety or neurotic defenses.								
6. TENSION	Physical and motor manifestations of tension, 'nervousness' and heightened activation level. Tension should be rated solely on the basis of physical signs and motor behaviour and not on the basis of subjective experiences of tension reported by the patient.								

RATING SCALE

	0	1	2	3	4	5	6	7	
Not assessed	Not Present	Very Mild	Mild	Moderate	Moderately Severe	Severe	Extremely Severe		RATING
<hr/>									
7. MANNERISMS AND POSTURING	Unusual and unnatural motor behaviour, the type of motor behaviour which causes certain mental patients to stand out in a crowd of normal people. Rate only abnormality of movements; do not rate simple heightened motor activity here.								
<hr/>									
8. GRANDIOSITY	Exaggerated self-opinion, conviction of unusual ability or powers. Rate only on the basis of patient's statements about himself or self-in-relation-to-others, not on the basis of his demeanour in the interview situation.								
<hr/>									
9. DEPRESSIVE MOOD	Despondence in mood, sadness. Rate only degree of despondency; do not rate on the basis of interferences concerning depression based upon general retardation and somatic complaints.								
<hr/>									
10. HOSTILITY	Animosity, contempt, belligerence, disdain for other people outside the interview situation. Rate solely on the basis of the verbal report of feelings and actions of the patient towards others; do not infer hostility from neurotic defenses, anxiety or somatic complaints. (Rate attitude toward interviewer under 'unco-operativeness').								
<hr/>									
11. SUSPICIOUS-NESS	Belief (delusional or otherwise) that others have now, or have had in the past, malicious or discriminatory intent toward the patient. On the basis of verbal report, rate only those suspicions which are currently held, whether they concern past or present circumstances.								
<hr/>									
12. HALLUCINATORY BEHAVIOUR	Perceptions without normal external stimulus correspondence. Rate only those experiences which are reported to have occurred within the last week and which are described as distinctly different from the thought and imagery processes of normal people.								

RATING SCALE

0	1	2	3	4	5	6	7
Not Assessed	Not Present	Very Mild	Mild	Moderate	Moderately Severe	Severe	Extremely Severe

RATING

13. MOTOR RETARDATION	Reduction in energy level evidenced in slowed movements. Rate on the basis of observed behaviour of the patient only; do not rate on basis of patient's subjective impression of own energy level.
--------------------------	--

14. UNCO- OPERATIVE- NESS	Evidence of resistance, unfriendliness, resentment, and lack of readiness to co-operate with the interviewer. Rate only on the basis of the patient's attitude and responses to interviewer and the interview situation; do not rate on basis of reported resentment or unco-operativeness outside the interview situation.
---------------------------------	---

15. UNUSUAL THOUGHT CONTENT	Unusual, odd, strange or bizarre thought content. Rate here the degree of unusualness, not the degree of disorganization of thought processes.
-----------------------------------	--

16. BLUNTED AFFECT	Reduced emotional tone, apparent lack of normal feeling or involvement.
-----------------------	---

17. EXCITEMENT	Heightened emotional tone, agitation, increased reactivity.
----------------	---

18. DISORIENT- TATION	Confusion or lack of proper association for person, place or time.
--------------------------	--

APPENDIX 4 E

MENTAL STATUS QUESTIONNAIRE

- | | | |
|---|-------|------------------------|
| 1. Where are we now? | | Place |
| 2. Where is this place located? | | Place |
| 3. What is the day of the month? | | Time |
| 4. What month is it? | | Time |
| 5. What year is it? | | Time |
| 6. How old are you? | | Memory |
| 7. When is your birthday? | | Memory |
| 8. In what year were you born? | | Memory |
| 9. Who is Prime Minister of South Africa? | | General
Information |
| 10. Who was Prime Minister before him? | | General
Information |

Score

8 - 10

5 - 7

2 - 4

0 - 1

Chronic Brain Syndrome

Absent - Mild

Mild - Moderate

Moderate - Severe

Severe

APPENDIX 4 F

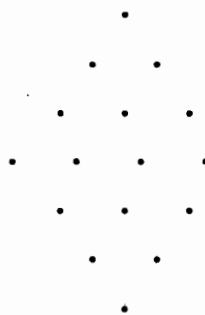
BENDER-GESTALT TEST (1938)

(Each of the three designs presented individually to the subject for copying on a single 8½ x 11 sheet of paper).

Design 1



Design 3



Design 8



Scoring : Three designs (No.1, No.3, and No.8) are scored according to the system described by Pascal and Suttell (1951). The minimum score is 1; the maximum score is indefinite. The higher the score, the greater the pathology. The score given here is the total of the scores for these three designs.

Condensed Scoring Manual for the Bender Gestalt Test :

This condensed scoring manual for designs No.1, No.3, and No.8 of the Bender-Gestalt Test will be useful for the reference of experienced scorers and for those who wish to gain some understanding of the scoring system. No one should attempt to learn to score the BGT from this condensed manual; for this it is essential that the complete scoring manual with examples in Pascal's book be consulted and that the reliability of the scorer be checked against the protocols in that book.

The administration of the test is simple. The subject is presented with each of the three designs in succession and asked to draw them exactly as he sees them, all three designs being drawn on a single sheet of paper, the answer sheet. He is given no help by the interviewer even in cases of extreme sight difficulty. He is not permitted to erase, although Pascal did permit erasure (if, contrary to instructions, erasure does occur, completely erased portions are not scored). The interviewer notes on the answer sheet its orientation (the position in which the subject held it) for each design; the interviewer also notes the orientation of the stimulus sheet on which the design was presented if the subject did not hold it in the usual upright position.

The designs as reproduced by the subject are assigned a score if they exhibit any of certain deviations from the original designs designated on the scoring sheet and explained more fully in this manual. No score is given unless a deviation is present; thus, a low score indicates relatively faithful reproduction of the designs and a high score indicates considerable discrepancy between the original designs and the subject's reproduction of them. A design subtotal is found for each design by adding up the scores, if any, given for that design. A total score for the test is found by adding the three design totals, except that if all the design totals are zero, the total score is one.

Reference: Pascal, Gerald R., and Suttell, Barbara J., The Bender-Gestalt Test: Quantification and Validity for Adults.
New York: Grune and Stratton, 1951.

¹Prepared by James Gradolph. "Adaptation and Survival Under Stress in the Aged." United States Public Health Service, National Institute of Child Health and Human Development, HD 00364. Principal investigator Morton A. Lieberman. Project director, Sheldon S. Tobin. Department of Psychiatry and Committee on Human Development, University of Chicago, 1963.

Design 1

Wavy Line (Score 2)

For this deviation to be scored the dots should form a distinctly wavy line. Only gross deviations from a straight line are scored. In cases of doubt, this item is not scored.

Dashes, Dots, Circles (Score 3)

This deviation is scored when there is variability in the reproduction of the stimulus, i.e., when dots and dashes, dots and circles, dashes and circles, or all three are used in the reproduction. The item is scored when two or more dots are converted to dashes or circles. It is not scored when all the dots, or all except one dot, are converted to dashes or to circles. A dash is defined as a line of at least 1/16 inch; a circle should be clear and unfilled. Enlarged dots and partially-filled circles are not considered circles. In cases of doubt, this item is not scored.

Dashes (Score 2)

For this deviation to be scored, all the dots, or all except one dot, must be converted to dashes, i.e., lines of 1/16 inch or longer either horizontal or vertical. If, in a line of dashes, two or more of the elements remain dots as in the stimulus, the reproduction is instead scored for variability, item 2 above.

Circles (Score 8)

For this deviation to be scored, all the dots, or all except one dot, must be converted to clear, unfilled circles. If in a line of such circles two or more of the elements remain dots, the reproduction is instead scored to variability, item 2 above.

Number of Dots (Score 2 for each)

The stimulus for design 1 consists of 12 dots. If in the reproduction the number of dots is less than 10 or more than 14 and the dots are yet a part of the design, not "extra scattered" dots, the item is scored. For each dot lacking or in excess of this tolerance, the score is 2; e.g., if the reproduction consists of 8 dots, the score for this item would be 4. If there are 6 or fewer dots, the reproduction is instead scored for "part of design missing," item 10.

Double Row (Score 8)

This item is scored when the design is reproduced on two lines instead of one. The deviation occurs when the subject, lacking in judgement, begins the design in spite of insufficient space, and when unable to complete the design on one line, continues on the next. The double row deviation differs from that scored under item 8, "second attempt," on the number of dots present.

Workover (Score 2)

Most normal subjects reproduce the stimulus by single dots or by slightly thickened dots, i.e., small, filled circles. Some subjects, however, so belabor the dots that they become large and appear to result from the expenditure of a great deal of effort. Such elaborations are scored as workover. Scorable workover occurs in three instances:

(1) when a single dot is so worked-over, so excessively belabored, that it stands out from the line of dots; (2) when three or more dots are so worked-over that they differ from the remaining dots, although not to quite so great an extent; (3) when all the dots appear to result from a great deal of elaboration.

Second Attempt (Score 3 for each)

When the subject makes (and fails to erase) more than one attempt to reproduce the design, the item is scored. Attempts crossed out or incompletely erased are scored. The score is 3 for each such attempt.

Rotation (Score 8)

This item is scored if the design is reproduced vertically instead of horizontally, or if the reproduction is rotated from the horizontal by 45 or more. Scorable rotations may come about (1) by inversion of the reproduction from a properly orientated stimulus card, or (2) by a turning of the stimulus card by the subject. Nonscorable rotations may result from turning the answer sheet, e.g., when the subject turns the paper to make more economical use of the space.

Part of the Design Missing (Score 8)

The item is scored if the design is reproduced with six or fewer dots.

Design 3

Asymmetry (Score 3)

For the item to be scored, the asymmetry should be pronounced. Three types of asymmetry are scored: (1) spacing asymmetry, in which the space between the dots varies markedly; (2) angle asymmetry, in which there is great disparity in the angles from the axis; and (3) dot asymmetry, in which there is an uneven number of dots on either side of the axis. The dots of the arrow-head should be approximately equidistant from the axis, and should make approximately equal angles with it. Asymmetry is not scored when the design is scored for "distortion", item 8.

Dots, Dashes, Circles (Score 3)

This item is scored in the same manner as item 2 for design 1.

Dashes (Score 2)

This item is scored in the same manner as item 3 for design 1.

Circles (Score 8)

This item is scored in the same manner as item 4 for design 1.

Number of Dots (Score 2)

The item is scored when there are more or fewer than 16 dots, dashes, or circles in the reproduction. The total score for this deviation is 2. The item may be scored when the design is scored for "distortion", item 8.

Extra Row (Score 8)

This deviation is rarely encountered. The item is scored when there is an extra row of dots in the reproduction.

Blunting (Score 8)

The point of the arrow should be obliterated to score this item. Rounding of the arrow with the middle dot of the first row at the center of the curve is not scored. Blunting is not scored when the design is scored for "distortion", item 8.

Distortion (Score 8)

To score there should be destruction of the gestalt, resulting in a loose conglomeration of dots or in an extreme departure from the stimulus. If an arrowhead, using all the dots roughly patterned after the stimulus, is at all discernible, the item is not scored.

Guide Lines (Score 2)

Where lines are made to guide the placement of the dots, dashes, or circles, the item is scored.

Workover (Score 2)

This item is scored in the same manner as in item 7 for design 1.

Second Attempt (Score 3 for each)

This item is scored in the same manner as item 8 for design 1.

Rotation (Score 8)

Rotation is scored for design 3 when the design is rotated 45 , 90 , or 180 (or any intermediate angle) from its proper horizontal axis, whether the deviation occurs in the actual reproduction or in previous turning of the stimulus card. Rotation of the answer paper is not scored.

Part of the Design Missing (Score 8)

The item is scored when one of the rows is completely missing in the reproduction. In such a case the "number of dots", item 5, is not scored unless there is a deviation in the number of dots in one of the remaining rows.

Design 8

Ends of the Lines Not Joined (Score 8)

In reproducing design 8 the subject may fail to join the ends of the lines forming the hexagon and/or the diamond. The deviation is scored when: (1) three or more gaps of 1/16 inch occur in either or both figures, and (2) two gaps occur, one of which is approximately 1/8 inch. The scoring is, in general, a matter for judgement and not rigid.

Angles Extra (Score 3)

The item is scored when an extra angle occurs in either the hexagon or the diamond. The deviation may occur either: (1) when there is arbitrary addition of an extra angle, or (2) when there occur abrupt changes in the direction of the straight lines. An abrupt change in direction may constitute a well-defined extra angle, or it may be a sharp curve. A curved change in direction should be pronounced. In cases of doubt, a ruler may be held tangent to the curved line; the angle thus formed should be approximately 20° or more for scorable deviation.

Angles Missing (Score 3)

The item is scored when an angle is missing in either the hexagon or the diamond. The item is not scored when a curve constituting a pronounced change in direction (as defined in item 2) is substituted for the angle. In cases of doubt, the item is not scored. This item is not scored when either the hexagon, or the diamond is scored for "part of design missing", item 12, unless the other figure, the one not scored for item 12, has an angle missing.

Extra Scattered Dots and/or Dashes (Score 3)

To score, there must occur in the reproduction at least two dots and/or dashes which are not integrated into the design. These meaningless additions may result from touching-up the reproduction, or from some sort of peculiar "doodling" on the side. The dots and dashes should be distinct to be scored and should not be confused with imperfections in the paper or with dots and dashes which may occur as a result of dropping a pencil.

Double Line (Score 1 for each)

Each time a distinct double line appears in the reproduction, the score is 1. Double line is not scored when there is consistent sketching unless such a line is distinctly outside the line of sketching. Double line is not scored when the double line is actually a second attempt superimposed on the first. Decision as to which item to score, double line or second attempt, is a matter for judgement; usually a second attempt is obvious.

Tremor

This item was not scored.

Distortion (Score 8 for each)

Distortion may occur in three ways: (1) when the design is extremely disproportionate in its length/width ratio; (2) when the diamond overlaps the hexagon by more than $\frac{1}{3}$ of its area, when the diamond is so small as to cover only $\frac{2}{3}$ the distance between the sides of the hexagon (or when the diamond is placed in one of the extreme thirds of the hexagon); and (3) when the figure is reproduced in an otherwise markedly distorted manner. The reproduction may be scored for one, two, or all three types of distortion, although more than one rarely occurs; the scores are accordingly 8, 16, or 24 for this item. In general the scoring is a matter for judgement; in cases of doubt, the item is not scored. One example given by Pascal of "reproduction in a markedly distorted manner" is the displacement of opposing angles in the hexagon by more than 30°.

Guide Lines (Score 2)

The item is scored when lines or dots are made to control the placement of the design. It is also scored where consistent sketching occurs.

Workover (Score 2)

Most normal subjects reproduce the stimulus by single lines. Some subjects, however, superimpose several lines on the single lines. When such elaboration results in a solid line of at least $\frac{1}{16}$ inch, workover is scored. The workover may be of the entire line(s) or of only a portion of the line(s). Some subjects may reproduce the design by sketched lines. In differentiating a worked-over line from one thickly sketched, the matter of contrast is important. Sketched lines, short light lines used to delineate the design, may become at some points $\frac{1}{16}$ inch or wider; unless such a widening of the sketched line is solid and contrasted in darkness with the rest of the line, workover is not scored. (Sketched lines are scored for guide lines, item 8).

Second Attempt (Score 3 for each)

The item is scored when the subject makes more than one attempt to reproduce the design and fails to erase his first attempts. Second attempt may occur with design 8 in either of two ways: (1) the subject may start a reproduction, give up, and start afresh a second reproduction, or (2) the subject may superimpose the second attempt on the first. The score is 3 for each attempt. This item must not be confused with "Double lines". A double line usually involves only one side of the diamond or less or only a short distance on the hexagon. Thus, scoring "second attempt" becomes a matter of judgement, the question for decision being whether the reproduction appears to result from an actual second attempt at reproducing the design or from an adjustment or correction line made on the one reproduction (termed here "double line").

Rotation (Score 8)

The item is scored when the base of the design is rotated 45° or more from the horizontal.

Part of the Design Missing (Score 8)

The item is scored when the subject omits the diamond, or at least 1/3 of either the diamond or the hexagon.

APPENDIX 4 G

DEPRESSION INVENTORY

A. (SADNESS)

- 0 I do not feel sad.
- 1 I feel blue or sad.
- 2a I am blue or sad all the time and I can't snap out of it.
- 2b I am so sad or unhappy that it is quite painful.
- 3 I am so sad or unhappy that I can't stand it.

B. (PESSIMISM)

- 0 I am not particularly pessimistic or discouraged about the future.
- 1a I feel discouraged about the future.
- 2a I feel I have nothing to look forward to.
- 2b I feel that I won't ever get over my troubles.
- 3 I feel that the future is hopeless and that things cannot improve.

C. (SENSE OF FAILURE)

- 0 I do not feel like a failure.
- 1 I feel I have failed more than the average person.
- 2a I feel I have accomplished very little that is worthwhile or that means anything.
- 2b As I look back on my life all I can see is a lot of failures.
- 3 I feel I am a complete failure as a person (parent, husband, wife).

D. (DISSATISFACTION)

- 0 I am not particularly dissatisfied.
- 1a I feel bored most of the time.
- 1b I don't enjoy things the way I used to.
- 2 I don't get satisfaction out of anything any more.
- 3 I am dissatisfied with everything.

E. (GUILT)

- 0 I don't feel particularly guilty.
- 1 I feel bad or unworthy a good part of the time.
- 2a I feel quite guilty.
- 2b I feel bad or unworthy practically all the time now.
- 3 I feel as though I am very bad or worthless.

F. (EXPECTATION OF PUNISHMENT)

- 0 I don't feel that I am being punished.
- 1 I have a feeling that something bad may happen to me.
- 2 I feel I am being punished or will be punished.
- 3a I feel I deserve to be punished.
- 3b I want to be punished.

G. (SELF-DISLIKE)

- 0 I don't feel disappointed in myself.
- 1a I am disappointed in myself.
- 1b I don't like myself.
- 2 I am disgusted with myself.
- 3 I hate myself.

H. (SELF-ACCUSATIONS)

- 0 I don't feel I am any worse than anybody else.
- 1 I am critical of myself for my weakness or mistakes.
- 2. I blame myself for my faults.
- 3 I blame myself for everything bad that happens.

I. (SUICIDAL IDEAS)

- 0 I don't have any thoughts of harming myself.
- 1 I have thoughts of harming myself but I would not carry them out.
- 2a I feel I would be better off dead.
- 2b I feel my family would be better off if I were dead.
- 3a I have definite plans about committing suicide.
- 3b I would kill myself if I could.

J. (CRYING)

- 0 I don't cry any more than usual.
- 1 I cry more now than I used to.
- 2 I cry all the time now. I can't stop it.
- 3 I used to be able to cry but now I can't cry at all even though I want to.

K. (IRRITABILITY)

- 0 I am no more irritated now than I ever was
- 1 I get annoyed or irritated more easily than I used to.
- 2 I feel irritated all the time.
- 3 I don't get irritated at all at the things that used to irritate me.

L. (SOCIAL WITHDRAWAL)

- 0 I have not lost interest in other people.
- 1 I am less interested in other people now than I used to be.
- 2 I have lost most of my interest in other people and have little feeling for them.
- 3 I have lost all my interest in other people and don't care about them at all.

M. (INDECISIVENESS)

- 0 I make decisions about as well as ever.
- 1 I try to put off making decisions.
- 2 I have great difficulty in making decisions.
- 3 I can't make any decisions at all any more.

N. (BODY IMAGE CHANGE)

- 0 I don't feel I look any worse than I used to.
- 1 I am worried that I am looking old or unattractive.
- 2 I feel that there are permanent changes in my appearance and they make me look unattractive.
- 3 I feel that I am ugly or repulsive looking.

O. (WORK RETARDATION)

- 0 I can work about as well as before.
- 1a It takes extra effort to get started at doing something.
- 1b I don't work as well as I used to.
- 2 I have to push myself very hard to do anything.
- 3 I can't do any work at all.

P. (INSOMNIA)

- 0 I can sleep as well as usual.
- 1 I wake up more tired in the morning than I used to.
- 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
- 3 I wake up early every day and can't get any more than 5 hours sleep.

Q. (FATIGABILITY)

- 0 I don't get any more tired than usual.
- 1 I get tired more easily than I used to.
- 2 I get tired from doing anything.
- 3 I get too tired to do anything.

R. (ANOREXIA)

- 0 My appetite is no worse than usual.
- 1 My appetite is not as good as it used to be.
- 2 My appetite is much worse now.
- 3 I have no appetite at all any more.

S. (WEIGHT LOSS)

- 0 I haven't lost much weight, if any, lately.
- 1 I have lost more than 5 pounds.
- 2 I have lost more than 10 pounds.
- 3 I have lost more than 15 pounds.

T. (SOMATIC PREOCCUPATION)

- 0 I am no more concerned about my health than usual.
- 1 I am concerned about aches and pains OR upset stomach OR constipation.
- 2 I am so concerned with how I feel or what I feel that its hard to think of much else.
- 3 I am completely absorbed in what I feel.

U. (LOSS OF LIBIDO)

- 0 I have not noticed any recent change in my interest in sex.
- 1 I am less interested in sex than I used to be.
- 2 I am much less interested in sex now.
- 3 I have lost interest in sex completely.

APPENDIX 4 H

LIFE SATISFACTION INDEX

	<u>Agree</u>	<u>Disagree</u>	<u>?</u>
1. As I grow older, things seem better than I thought they would be.
2. I have had more opportunities in life than most of the people I know.
3. This is the dulllest time of my life.
4. I am just as happy as when I was younger.
5. These are the best years of my life.
6. Most of the things I do are boring or monotonous.
7. The things I do are as interesting to me as they ever were.
8. As I look back on my life, I am fairly well satisfied.
9. I would not change my past life even if I could.
10. Compared to other people my age, I make a good appearance.
11. I have made plans for things I'll be doing in the future.
12. When I look back over my life, I didn't get most of the important things I wanted.
13. Compared to other people, I feel low or down in the dumps more often.
14. I have generally got what I expected out of life.
15. In spite of what people say, the lot of the average person is getting worse, not better.

APPENDIX 4 I

THE LIEBERMAN-ROSNER SELF SORT TASK

The Forty-Eight Self-Sort Items Grouped by Sixteen Areas and the Intensity (from 1 to 3) of Each Item (in Parentheses are the Weightings of Each Item for Scoring Self-Esteem).

Power

1. (+1) I enjoy being in charge of things
2. (+2) I am a good leader.
3. (-2) I am somewhat of a dominating or bossy person.

Success

1. (+2) People think well of me.
2. (+1) I believe that I am an important person.
3. (0) I frequently give advice to others.

Narcissism

1. (+2) I am a self-respecting person.
2. (+1) I am an independent and self-confident person.
3. (0) I am proud and self-satisfied.

Exploitation

1. (+2) I am able to take care of myself.
2. (-1) I am a competitive person.
3. (-2) I can be a cold and unfeeling person.

Punitive Hostility

1. (+1) I am firm but fair in my relations with other people.
2. (+1) I can reproach people when necessary.
3. (-1) I am short-tempered and impatient with mistakes other people make.

Pure Hostility

1. (+2) I am frank and honest with people.
2. (0) I am critical of other people.
3. (-1) I frequently get angry with other people.

Unconventional Activity

1. (+1) When necessary, I can complain about things that bother me.
2. (+1) I will argue back when I feel I am right about something.
3. (-1) At times I act rebellious or feel bitter about something.

Deprivation

1. (0) I am frequently disappointed by other people.
2. (-2) I am touchy and easily hurt by others.
3. (-2) It is hard for me to trust anyone.

Masochism

1. (+1) I am able to criticize or find fault with myself.
2. (-1) I am easily embarrassed.
3. (-1) I am rather timid and shy.

Weakness

1. (+1) I can be obedient when necessary.
2. (-1) Usually I give in without too much of a fuss.
3. (-2) Frequently I feel weak or helpless.

Conformity

1. (+1) I am grateful for what other people do for me.
2. (0) I am often helped by other people.
3. (0) I hardly ever talk back.

Trust

1. (+2) I am a trusting person.
2. (-1) I prefer to let other people make decisions for me.
3. (-1) I will believe anyone.

Collaboration and Agreeability

1. (+2) I am a cooperative person.
2. (0) I want everyone to like me.
3. (0) I agree with what everyone says.

All Forms of Pure Love

1. (+2) I am a friendly person.
2. (+2) I am an affectionate and understanding person.
3. (+1) I love everyone.

Tenderness

1. (+2) I am considerate of others.
2. (+1) I am somewhat tender and soft-hearted.
3. (-1) I am too lenient with other people.

Generosity

1. (+1) Generally I can be counted upon to help others.
2. (+1) I often take care of other people.
3. (+3) I spoil people with kindness.

APPENDIX 4 J

Osgood Self-Evaluation Scale (1957)

I have some other words here which describe how people think of themselves. I'd like you to make a choice.

For example: Do you think of yourself as being (present sheet)¹

Very Happy, Quite Happy, Happy, Neither Happy nor Sad, Sad, or very Sad?

(Have subject make choice. Repeat instructions if necessary. Interviewer will mark choice made).

Very Happy	Quite Happy	Happy	Neither Happy nor Sad	Sad	Quite Sad	Very Sad
Very Beautiful	Quite Beautiful	Good Looking	Neither Beautiful nor Ugly	A Little Ugly	Quite Ugly	Very Ugly
Very Foolish	Quite Foolish	A Little Foolish	Neither Foolish nor Wise	A Little Wise	Quite Wise	Very Wise
Very Good	Quite Good	Good	Neither Good nor Bad	Bad	Quite Bad	Very Bad
Very Un- success- ful	Quite Un- success- ful	Unsuc- cessful	Neither Success- ful nor Unsuc- cessful	Success- ful	Quite Suc- cess- ful	Very Suc- cess- ful

Scoring : Each of the five Osgood dimensions are scored on a 1-7 scale (where 7 represents the most positive end). By adding the scales, obtain range of 5-35 with high score being positive self-evaluation.

¹Each Osgood dimension is presented to the subject on a separate sheet of paper.

APPENDIX 4 K

SOCIAL INVOLVEMENT SCALE

Name :

Activities

(a) How often do you attend the Friendship Club?

1. several times each year.
2. at least once a year.
3. several times each month.
4. at least once a week.
5. never.

(b) How often do you go shopping or go to the tuckshop?

1. at least once a day.
2. several times each week.
3. at least once a week.
4. several times each month.
5. at least once a month.
6. several times each year.
7. at least once a year.
8. never.

(c) How often do you go to the hairdresser?

1. at least once a week.
2. at least once a month.
3. several times each year.
4. at least once a year.
5. never.

(d) How often do you attend church/synagogue?

1. at least once a day.
2. several times each week.
3. at least once a week.
4. several times each month.
5. at least once a month.
6. several times each year.
7. at least once a year.
8. never.

(e) How often do you play cards with the others?

1. at least once a day.
2. several times
3. at least once a week.
4. several times each month.
5. at least once a month.
6. several times each year.
7. at least once a year.
8. never.

(f) How often do you attend therapy or groups of any sort?

1. several times each week.
2. at least once a week.
3. several times each month.
4. several times each year.
5. at least once a month.
6. at least once a year.
7. several times each year.
8. never.

(g) How often do you watch T.V. with others?

1. at least once a day.
2. several times each week.
3. at least once a week.
4. several times each month.
5. at least once a month.
6. several times each year.
7. at least once a year.
8. never.

(h) How often do you visit with others in their rooms or homes?

1. several times each day.
2. at least once a day.
3. several times each week.
4. at least once a week.
5. several times each month.
6. at least once a month.
7. several times each year.
8. at least once a year.
9. never.

(i) How often do other people visit you in your room?

1. several times each day.
2. at least once a day.
3. several times each week.
4. at least once a week.
5. several times each month.
6. at least once a month.
7. several times each year.
8. at least once a year.
9. never.

(j) How often do you go out with other people?

1. at least once a day.
2. several times each week.
3. at least once a week.
4. several times each month.
5. at least once a month.
6. several times each year.
7. at least once a year.
8. never.

(k) How often does your family visit you?

1. at least once a day.
2. several times each week.
3. at least once a week.
4. several times each month.
5. at least once a month.
6. several times each year.
7. at least once a year.
8. never.

(l) How often do you go out with your family?

1. at least once a day.
2. several times each week.
3. at least once a week.
4. several times each month.
5. at least once a month.
6. several times each year.
7. at least once a year.
8. never.

APPENDIX 4 L

ASSESSMENT OF INTERPERSONAL QUALITIES

Rate the resident on the following dimensions:

(a) DEPTH	1	2	3	4	5
(b) WARMTH	1	2	3	4	5
(c) MOTIVATION	1	2	3	4	5
(d) COOPERATION	1	2	3	4	5
(e) SPONTANEITY	1	2	3	4	5

KEY

Note Scores of 1 = Not much

Scores of 5 = Greatest amount possible.

APPENDIX 4 M

Cattell (1962) Sixteen Personality Factor Test (Form C)¹

Introduction :

I am going to ask you some questions to see what opinions and interests you have about certain things. This is not a test and there are no right or wrong answers -- we are interested only in your own views. Here is a pack of cards, each of which has one question printed on it. Please read each question to yourself along with me as I read it to you. After each question, decide whether it applies to you as you are now.

For example :

I find it hard to wake up quickly in the morning ... Yes ... No.

I would rather spend an evening:

- A. Listening to good music;
- B. Reading an exciting story.

(Clarify any misunderstanding)

1. I could happily live alone, far from anyone, like a hermit.
2. When I see "sloppy" untidy people, I :
 - (A) Just accept it
 - (B) Get disgusted and annoyed.
3. It annoys me to hear people say they can do something better than others.
4. At a party I let others keep the jokes and stories going.
5. If I had more than enough money for ordinary daily needs, I would feel I should give the rest to a charity or other worthwhile cause.
6. Most people I see at a party are undoubtedly glad to meet me.
7. I enjoy daydreaming.

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8. I smile to myself at the big difference between what people do and what they say they do.
9. As a child I felt sad to leave home to go to school each day.
10. If a good remark of mine is passed by, I :
(A) Let it go.
(b) Give people a chance to hear it again.
11. When someone has bad manners I feel :
(A) It is not my business.
(B) I should show the person that people disapprove.
12. When I meet a new person I would rather :
(A) Discuss his politics and social views.
(B) Have him tell me some good, new jokes.
13. When I plan something, I like to do so quite alone, without any outside help.
14. I avoid spending time dreaming about "what might have been".
15. When I am going to catch a train, I get a little hurried, tense, or anxious, though I know I have time.
16. I could be happy in a job where I have to listen to unpleasant complaints all day.
17. I always have lots of energy at times when I need it.
18. I make smart, sarcastic remarks to people if I think they deserve it.
19. I greatly enjoy all large gatherings, like parties or dances.
20. I feel that :
(A) Some jobs just do not need doing as carefully as others.
(B) Any job should be done thoroughly if you do it at all.
21. In streets or stores I dislike the way some people stare.
22. I would rather be :
(A) A Rabbi/Priest.
(B) A General.
23. If a neighbor cheats me over small things, I would rather humor him than show him up.
24. I would rather see :
(A) A good movie of hardy, pioneering days.
(B) A clever movie farce or skit on the society of tomorrow.
25. When I have been put in charge of a thing I insist that my instructions are followed or else I resign.
26. I find it wise to avoid too much excitement because it tends to wear me out.

27. For relaxation I prefer :
(A) Sports and games.
(B) Debates and intellectual activities.
28. I feel it is cruel to vaccinate very small children, even against contagious diseases, and parents have a right to stop it.
29. I put my faith more in :
(A) Insurance.
(B) Good fortune.
30. I can forget my worries and responsibilities whenever I need to.
31. In a factory I would rather be in charge of :
(A) Machinery or keeping records.
(B) Talking to and hiring new people.
32. If I had my life to live over again, I would :
(A) Plan it very differently.
(B) Want it much the same.
33. I am quite happy to be waited on, at appropriate times, by personal servants.
34. I feel a bit awkward in company and do not show up quite so well as I should.
35. I think people should observe moral laws more strictly than they do.
36. Some things make me so angry that I find it best not to speak.
37. I can do hard physical work without feeling worn out as soon as most people.
38. I think most witnesses tell the truth even if it becomes embarrassing.
39. I would prefer the life of :
(A) An artist.
(B) An insurance man.
40. I think this country would do better to spend more on :
(A) Armaments.
(B) Education.
41. I would rather spend an evening :
(A) In a hard game of cards.
(B) Looking at photos. of past vacations.
42. I would rather read :
(A) A good historical novel.
(B) An essay by a scientist on harnessing world resources.
43. There are really more nice people than trouble makers in the world.
44. I honestly think I am more planful, energetic, and ambitious than many perhaps equally successful people.

45. There are times when I do not feel in the right mood to see anyone :
(A) Very rarely.
(B) Quite often.
46. I would rather be :
(A) In a business office, organizing and seeing people.
(B) An architect, drawing plans in the back room.
47. I am always a sound sleeper, never walking or talking in my sleep.
48. I can look anyone in the eye and tell a lie with a straight face
(if for a right end).
49. I have been active in organizing a group or club.
50. I admire more :
(A) A clever but undependable man.
(B) An average man but strong enough to resist temptations.
51. When I make a fair complaint I always get matters adjusted to my satisfaction.
52. Discouraging circumstances can bring me near to tears.
53. I believe anyone will tell a lie to keep out of trouble.
54. There are times, every day, when I want to enjoy my own thoughts, uninterrupted by other people.
55. I get annoyed at being held up by small rules and regulations which, I admit, are really necessary.
56. I think much so-called modern education is less wise than the old rule "spare the rod and spoil the child".
57. I learned more in school days by :
(A) Going to class.
(B) Reading a book.
58. I avoid getting involved in organizations.
59. When a problem gets hard and there is a lot to do, I try :
(A) A different problem.
(B) A different attack on the same problem.
60. Sometimes I have strong feelings that seem to arise without much actual cause.
61. I am happy to oblige people by making appointments at times they like, even if a bit inconvenient to me.
62. I tend to be critical of other people's work.
63. I would rather do without something than put a waiter or waitress to a lot of extra trouble.
64. I love to travel -- anytime.

65. I have sometimes come near to fainting, at a violent pain or the sight of blood.
66. I greatly enjoy talking to people about everyday problems.
67. I would rather be :
(A) A construction engineer.
(B) A teacher of social ideas and manners.
68. I have to stop myself from getting too involved in trying to straighten out other people's problems.
69. I find the conversation of my neighbours dull and boring :
(A) In most cases.
(B) Only in a few.
70. I like to take on problems that other people have made a mess of.
71. I think every story and movie should teach us a lesson.
72. More trouble arises from people :
(A) Changing and meddling with ways that are already o.k.
(B) Turning down new, promising methods.
73. I sometimes hesitate to use my own ideas, for fear they might be impractical.
74. Straightlaced, strict people do not seem to get on well with me.
75. My memory does not change much from day to day.
76. I am more restrained than most people in saying what my feelings are.
77. I get impatient when people delay me unnecessarily.
78. People say that I like to have things done my own way.
79. I am well described as a happy-go-lucky, easy-going person.
80. With a little spare time, I :
(A) Use it in chatting and relaxing.
(B) Plan to fill it with special jobs.
81. I am shy, and careful, about making friendships with new people.
82. I think that what people say in poetry could be said just as easily in plain words.
83. I suspect that people who act friendly to me can be disloyal behind my back :
(A) Yes, generally.
(B) No, rarely.
84. It is more important for a man to be concerned :
(A) About the basic meaning of life.
(B) To make a good income for his family.

Subject Number _____

CATTELL ANSWER SHEET

Factor	Make a cross through response chosen												Total
A	¹ Yes	No	¹⁶ Yes	No	³¹ A	B	⁴⁶ A	B	⁶¹ Yes	No	⁷⁶ Yes	No	
C	² A	B	¹⁷ Yes	No	³² A	B	⁴⁷ Yes	No	⁶² Yes	No	⁷⁷ Yes	No	
E	³ Yes	No	¹⁸ Yes	No	³³ Yes	No	⁴⁸ Yes	No	⁶³ Yes	No	⁷⁸ Yes	No	
F	⁴ Yes	No	¹⁹ Yes	No	³⁴ Yes	No	⁴⁹ Yes	No	⁶⁴ Yes	No	⁷⁹ Yes	No	
G	⁵ Yes	No	²⁰ A	B	³⁵ Yes	No	⁵⁰ A	B	⁶⁵ Yes	No	⁸⁰ A	B	
H	⁶ Yes	No	²¹ Yes	No	³⁶ Yes	No	⁵¹ Yes	No	⁶⁶ Yes	No	⁸¹ Yes	No	
I	⁷ Yes	No	²² A	B	³⁷ Yes	No	⁵² Yes	No	⁶⁷ A	B	⁸² Yes	No	
L	⁸ Yes	No	²³ Yes	No	³⁸ Yes	No	⁵³ Yes	No	⁶⁸ Yes	No	⁸³ A	B	
M	⁹ Yes	No	²⁴ A	B	³⁹ A	B	⁵⁴ Yes	No	⁶⁹ A	B	⁸⁴ A	B	
N	¹⁰ A	B	²⁵ Yes	No	⁴⁰ A	B	⁵⁵ Yes	No	⁷⁰ Yes	No	⁸⁵ Yes	No	
O	¹¹ A	B	²⁶ Yes	No	⁴¹ A	B	⁵⁶ Yes	No	⁷¹ Yes	No	⁸⁶ Yes	No	
Q ₁	¹² A	B	²⁷ A	B	⁴² A	B	⁵⁷ A	B	⁷² A	B	⁸⁷ A	B	
Q ₂	¹³ Yes	No	²⁸ Yes	No	⁴³ Yes	No	⁵⁸ Yes	No	⁷³ Yes	No	⁸⁸ Yes	No	
Q ₃	¹⁴ Yes	No	²⁹ A	B	⁴⁴ Yes	No	⁵⁹ A	B	⁷⁴ Yes	No	⁸⁹ Yes	No	
Q ₄	¹⁵ Yes	No	³⁰ Yes	No	⁴⁵ A	B	⁶⁰ Yes	No	⁷⁵ Yes	No	⁹⁰ Yes	No	

E D U C A T I O N A L S T A T U S

Std. 2-5.	Std. 6-7.	Std. 8-10.	Technical College	University

OCCUPATIONAL STATUS

Professional/ Managerial	Technical	Artisan Unskilled	Unskilled Semiskilled	Never worked
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Occupation : This includes the highest possible position the subject has held, even if not working presently.

Professional : Requiring university certificate, e.g. doctors, lawyers, engineers, teachers.

Technical : Requiring a certain amount of professional training, not at a university, e.g. commercial clerk, proof reader, bank clerk.

Artisan/
Skilled trade : e.g. shoemaker, dressmaker, train inspector.

Unskilled/
Semiskilled : i.e. no specific training required, e.g. companion, governess, housekeeper, shop assistant.

Never worked : Has not worked except for very short periods.

Appendix 5

Personality Profiles of Therapists as Measured by the 16 PF.

<u>Personality Factors</u>	<u>Crisis Intervenor</u>	<u>Social Attachment and Activity Volunteer</u>
FACTOR A	4	4
FACTOR C	4	4
FACTOR E	3	4
FACTOR F	4	5
FACTOR G	4	4
FACTOR H	4	2
FACTOR I	-	-
FACTOR L	2	2
FACTOR M	4	2
FACTOR N	3	4
FACTOR O	3	3
FACTOR Q ₁	4	2
FACTOR Q ₂	3	3
FACTOR Q ₃	3	3
FACTOR Q ₄	3	4

APPENDIX 6 :

CASE HISTORIES :

In this section, two case histories, from the CI and control group will be discussed in great detail.

1. SUBJECT FROM CONTROL GROUP

Identifying Information :

Name : Mr. J.

Age : 70 years. Date of Birth : 15 May, 1909

Marital Status : Widower

Number of Living Children : Childless

Referral Source : Family General Practitioner

Reason for Admission :

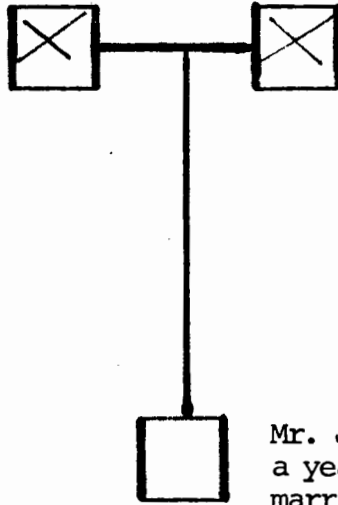
Mr. J's wife died of a sudden acute myocardial infarction.

12 weeks prior to his admission to the home. Unable to come to terms with his wife's death, Mr. J. became moderately depressed and was unable to care adequately for himself in the community.

Because he did not have any children or immediate family of his own to support him over this crisis, nor did he want to impose on friends, the new resident was particularly amenable to his G.P's suggestion that he go into an Old Age Home.

Family History :

Father died at age 75. Chronic pulmonary emphysema. A coal miner in Manchester. Seen as an aloof, distant figure, unable to show emotions - abused alcohol.



Mother died at age 79 - Ca. colon. Seen as a strong powerful personality - the central figure in family. Extremely close relationship and he relied on her a great deal. Numerous spontaneous abortions prevented birth of any other children.

Mr. J. age 70, born after a year of his parents' marriage.

Personal History :

Born in Manchester in 1909, unaware of details of birth and early milestones. Early childhood memories abound in themes of a distant, hard-working father who was quick to punish and seldom rewarded or praised him. Marital conflict was rife in the home. Consequently, there was a strong bond with the mother who Mr. J. sees as "holding the family together". He relied a great deal on her for both nurturance and support. Being an only child, he often felt lonely and isolated and described himself as a follower rather than a leader during his school years. Always relied on friends for direction.

Education :

Matriculated in Manchester and went on to study music where he obtained a diploma and was qualified to teach music.

Work History :

Taught music at various colleges in England for twenty years and then emigrated to South Africa where he continued teaching and later joined an orchestra.

Marital History :

Mr. J. met his wife at a music concert in England and courted her for a period of two years prior to getting married. She is described as "the most perfect human being God has ever created". She was competent, unselfish and managed household activities and finance with care and skill.

Gynaecological problems prevented her from conceiving; however, Mr. J. reports that although they would have liked to have had children, they nevertheless became closer as a result of these circumstances.

The couple shared many common hobbies and travelled extensively. He described their lives together as having been filled with "sheer happiness and bliss". The sudden death of his wife was catastrophic for him.

Non-familial Relationships :

As all extended family were in England, Mr. and Mrs. J. formed a few meaningful relationships with close friends who they used to see fairly often.

Housing Arrangements :

He owned a house in a middle-class suburb where he had been living for the last ten years. With the death of his wife he was unable to maintain its upkeep and sold the house, with its memories, prior to moving into the aged home.

Financial Status :

Savings accumulated over many years have enabled Mr. J. to maintain a comfortable standard of living.

Recreation Hobbies and Interests :

Music, both performing and attending concerts occupied much leisure time. Reading and gardening were further hobbies. But since his wife's death, claims to have no interest for anything.

Habits :

He smokes fairly heavily. Prior to his wife's death he used to drink socially, but has subsequently attempted to treat his depression with the use of alcohol.

Alcoholic History :

Currently drinks a quarter jack of brandy every two days. Drinks mainly in the evening before going to sleep which prevents him from ruminating about past events.

Denies evidence of shakes, fits, or black-outs. Tended to minimise the fact that he might become dependent on alcohol.

Retirement :

This was not seen as a problem since he was able to continue developing his primary interests from home, especially with regards to musical appreciation. He also looked forward to being with his wife and to "growing old together".

Attitude to Aging :

Occasionally he would worry about the possibility of failing

health with the specific fear of being a wheel-chair patient. At times he feared widowhood and death, however, this issue was seldom spoken about with his wife, since it proved to be too painful.

Current Health Status :

Is mildly emphysematous and suffers from osteo-arthritis. Consequently, he experiences mild pains, some stiffness and weakness and is on occasion short of breath. However, he is completely able to care for himself.

Current Social Functioning :

Prior to his wife's death, Mr. J. claims that he knew how to have a good time and could relate easily to people, enjoying their company. More recently, he doesn't feel like being with his friends and "doesn't have the energy to relate to people".

Mental State Examination :

Appearance and Behaviour :

Mr. J. is a thin, slightly built, grey-haired man who was slightly anxious but related easily during the interview situation. He spoke freely, often gesticulating with his hands to make a point. At times, he would break into spontaneous crying when talking or reflecting on his relationship with his wife.

Talk : Spontaneous to the point with no evidence of formal thought disorder.

Mood : Generally Mr. J's mood was judged to be moderately depressed and he often spoke touchingly of his desolation. "You lose your wife, you lose your home. You lose your health, it's only natural to feel

down sometimes. When a man loses his wife, it's like a bird with one wing. It's more than half of you gone. I sometimes take a drink to make me feel brighter". Associated with his subjective feelings of loss, he complained of anergia, insomnia and loss of appetite.

Delusions and Misinterpretations : nil of note.

Hallucinations : nil of note

Cognitive Functions :

(a) memory : Long term memory was good, with memory for recent events being good.

(b) He was oriented for time, place and person.

(c) His intelligence was judged to be above average.

(e) His attention and concentration was good.

Insight and Judgement :

Mr. J. saw his depression in relation to the recent death of his wife, but was undecided if he would be able to get over this crisis and viewed the future rather pessimistically questioning whether life had any meaning left for him. "I wonder whether I will ever recoup my zest for life?"

Provisional Formulation :

Mr. J. - a 70 year old retired widower, was referred to an old age home because his general practitioner felt that he was no longer able to manage his affairs in the community.

On admission he complained of feelings of loss and desolation as well as mild anergia, insomnia, and loss of appetite. These symptoms

have lasted for three months and were precipitated by the sudden death of his wife.

His early life was characterised by a disengaged relationship with a non-expressive, punitive father figure, and an over-involved, dependent attachment to a dominant mother. As a result he constantly sought relationships which would provide him with affirmation of his self worth and consequently his strivings towards independence were limited.

This pattern was repeated during his adult life where he chose a wife on whom he could depend for nurturance, support and direction and her recent death has left him in a helpless dependent position. The inability to come to terms with this significant loss has led him to experience a loss of interest in his usual activities and he now feels lonely, inadequate and sees little purpose in life. In an attempt to deal with these feelings, he has been treating himself with alcohol and in view of his strong dependency needs, this could prove problematic.

The above picture is consistent with the disequilibrium experienced by a mourning reaction in a dependent personality. Since Mr. J. has few environmental supports, placement into an old age home appears appropriate.

Re-Assessment at Six Weeks Post Admission :

Qualitatively, Mr. J. appeared more dishevelled and looked depressed. In the interim period between assessments, he had not received any therapy but had continued to medicate himself with alcohol, and was now unsure of how much he had consumed.

He was more hypochondriacal, appeared shaky and ill at ease and his interpersonal skills were not as good as on the previous occasion.

Mr. J. appeared more withdrawn and complained of feeling listless, apathetic, and seemed to be pre-occupied with self-denigration, illness

and death. His mood was flat, unanimated and he had difficulty responding to questions. His frustration tolerance was poor and he demonstrated flashes of irritability. He appeared mildly conceptually disorganized and was not orientated for time.

According to the nursing staff, he had not socialized adequately and would remain alone for long periods in his room, occasionally slipping out to a liquor store nearby. It was reported that one or two of the older residents had tried to make contact and establish rapport with Mr. J. but this appeared unsuccessful.

Follow-up Assessment at 3 months Post-Admission :

Mr. J. appeared drawn and seemed to have lost weight. He spoke in a slow and hesitant manner with a paucity of ideas. His general movements were retarded, and he had a blank vacant expression on his face and it appeared an effort for him to communicate.

He expressed the wish to die, saw no purpose in living and felt unworthy and unwanted. He complained that no one cared, that he had been cast aside and was a burden on all those around him.

His cognitive functioning had deteriorated considerably, with memory for recent events showing signs of impairment. He was disorientated for time and his attention and concentration was poor.

According to the staff, Mr. J. had become a management problem since he would often come into the home intoxicated and this apparently upset the other residents, many of whom attempted to befriend and counsel him.

At this stage, he was in need of psychiatric intervention and was referred to an outpatient clinic at a general hospital.

APPENDIX 6

2) Treatment of Mrs. M. aged 82, using Crisis Intervention (Brief Resume)

Previous Background :

Mrs. M. revealed little regarding her own parents. Her father came to C.T. at an early age from Holland. Her mother was 20 years younger than her father; Mrs M. being an only child. She vaguely described her mother as a domineering woman, her father was described as a hard-working man who, in his later life, was retrenched with no financial consideration from his employer of many years.

Mrs. M. married at the age of 23. She resided with husband's parents because he was only earning a small sum and they could not afford their own residence. No children, separated from husband after 10 years of stormy marriage and eventually obtained a divorce.

Her only relatives are two first cousins who live in another city and contribute financially to her maintenance. In receipt of O.A.P. Prior to admission she suffered cardiac failure and was hospitalized. Referred from hospital to aged home.

Session 1 :

Brief history-taking and contracting.

Session 2 :

At beginning of the session, Mrs. M. had a great need to express hostility towards the social worker in the hospital who made the referral. She was gradually helped to recognise and then to express that her negative feelings were probably an expression of her own resentment about

having moved into an aged home where there were quite a number of sick and senile patients. It was pointed out that some of that anger was protecting her and partially covered up some fear of losing control and becoming old and sick like others around her.

Session 3 :

Tried to explore to what positive use we would turn some of her anger. Worker allowed her to express it but pointed out the pitfalls that might occur if she couldn't get rid of it. Attempted to channel it into retaining some control and mastery of her environment by focusing on three areas :

- 1) Her future life in the aged home and what she could do to enhance it.
- 2) Her feelings about being in a home where she felt she "did not belong".
- 3) Her feelings about her failing health and the possibility of approaching death.

The remaining five interviews expanded upon these areas : With regard to the first area, Mrs. M. brought out in practically every interview that she was quite aware that she would have to fit into rules and regulations set up by the administration of the home. She came to see it as a task which she would be able to shoulder as a mature person who could take responsibility for her own actions. This was reinforced immensely by the worker, because to have this self-image enabled Mrs. M. to function quite adequately in other areas too.

Therapist also explored her negative feelings about being in a dependent state and eventually having to die in an institution. She herself brought this up repeatedly, usually relating how her grandmother died in her mother's arms, while her mother in turn died in her home

and how she had not "expected to end up like this". Worker verbalised some of her feelings for her because it was very difficult for her to do so. She responded always in a very positive manner to this, such as either pressing my hand or eagerly calling her favourite nurse aide to show worker off. The ability to express some negative feelings and have them accepted was very therapeutic for her. Attention of worker in interview gave resident a sense of containment - a nourishment to Mrs. M's ego.

Mrs. M. retained an inability to deal adequately with any "slight" however unintentional. Wanted some of her money from the resident social worker to give a gift. Resident social worker queried whether in fact she could afford it which made her angry. Crisis Therapist supported her wish and her right to show her gratefulness to the nurse in this particular manner.

On occasion she complained about the food and the delay in getting attention at times. Interpretation was made that part of her difficulty was that until recently she had been a very independent person who was able to manage her affairs well, therefore it was now doubly difficult to eat what someone else cooked and at a time which someone else decided on, and to have to wait a long time for someone to bring what she wanted. Mrs. M. nodded and then continued saying that her mother had died in her arms after she had cared for her for a long time.

Again an interpretation was made to her that she probably wished that she had a daughter to care for her now. Maybe she wished that the therapist could be her daughter, to make her feel loved and protected every time someone was rude to her. Mrs. M. answered that at times she realises and can face that she cannot have what she wants, but at other times she gets so angry at those around her, that she can hardly control a wish to scream at them. Worker supported her by saying that everyone

gets angry when their wishes are not fulfilled, but that she always regains her perspective and this again is a sign of her good sense and her adequacy. She answered that she and everybody else knew that she really didn't belong with these senile people. Worker again picked this up by saying that her original anger was a reaction to being brought here and seeing these other people, it may have frightened her and she may have feared that she might become like them. She denied this once again, saying that she would not become like them ever but admitted that it is an unpleasant reminder of approaching death.

Therapist said that it had been comforting to her mother to have her daughter by her side when death came and that she herself may be afraid she has to face it alone. It is frightening at first to think of death, because no one knows what it will be like. Mrs. M. retorted that she had always led an honest good life and hoped that God would approve of her. Her ambivalence was focused on and worker reiterated that we all have to face leaving this world at some time and that she has fears and anxiety about it which are difficult to put into words. Mrs. M. took worker's hand and pressed it close to her face. Sat like this in silence for a while. On terminating this particular session she pulled worker down to kiss her face saying that God had been good to her that day.

10th Session

Termination and Review